To facilitate the whole process, the World Health Organization had developed and given to the workshop participants background materials including guidelines for the preparation of district, provincial, and regional health sector profiles; formats for presentations and development of work-plans as well as hand outs on the methodology and for the process of the workshop.

4. OUTPUT OF THE WORKSHOP

4.1 The major output of the workshop are the five consolidated regional workplans, which include:

- the basic demographic data
- problem statement translated into overall goal and immediate objectives and related monitoring indicators
- results or outputs and the monitoring indicators to measure achievement of immediate objectives
- means of verification
- assumptions and pre-requisites, especially policy support frameworks and guidelines
- population groups by age and gender as primary beneficiaries of the planned interventions
- geographical priorities, if any
- detailed activities with timeframe and resources (financial, material and technical) required and the responsible institutions
- Contribution of the funding partners for each of the activity they have committed to assist and support.

4.2 Summary work-plans showing the demographic features of each region, the problem statements and the overall goal of their health programmes, description of each immediate objectives and indicators for monitoring progress of implementation and impact of each programme (see ANNEX I - V).

4.3 The local health authorities for the first time have indicated the funds available for the health sector in these five regions.

4.4 Stakeholder analysis, giving detailed information on the geographical presence, programming priorities, organisational mandate, modus operandi, etc of each of the participating agency.

4.5 The workshop also produced regional, provincial and district health profiles, which can be used for planning and evaluation of health programmes. Each region will establish a database on the available information and key indicators on the social and economic sector. See ANNEX VI – X for summary of regional health profiles.

4.6 The participants also discussed several key issues related to health policies in general and programme strategies in particular including coordination of activities among all stakeholders in the health sector. A number of recommendations to resolve the issues raised in the workshop were agreed upon for implementation. See ANNEX XI.

4.7 Among the more intangible outputs of the workshop are:

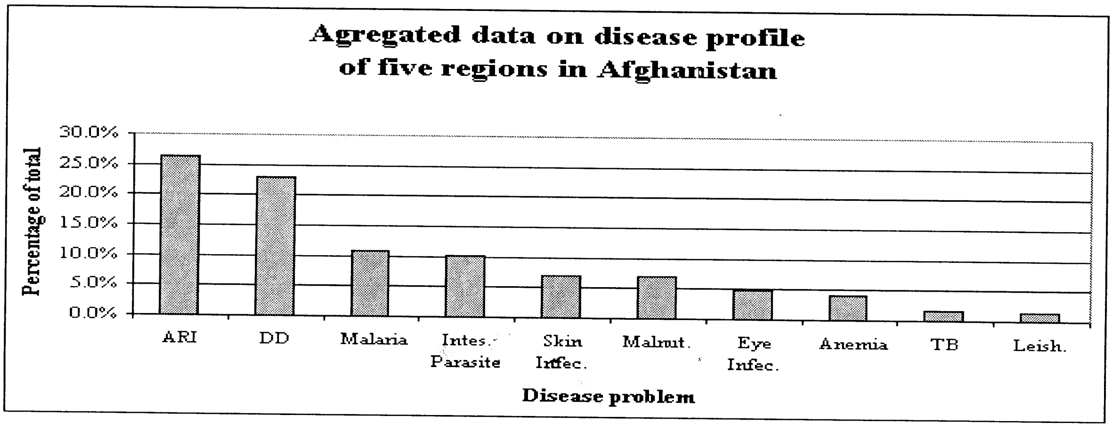
- orientation and capacity building of the participants in participatory and systematic planning methodology and process
- Trust-building amongst the various stakeholders of the health sector.

5. FINDINGS

As said earlier (section 4 on outputs of the Workshop) there are two specific and tangible outputs related with planning. These include: i) health profiles by provinces and regions, and ii) detailed work-plans for each of the five participating regions. This section makes an attempt to share some key findings of these two outputs.

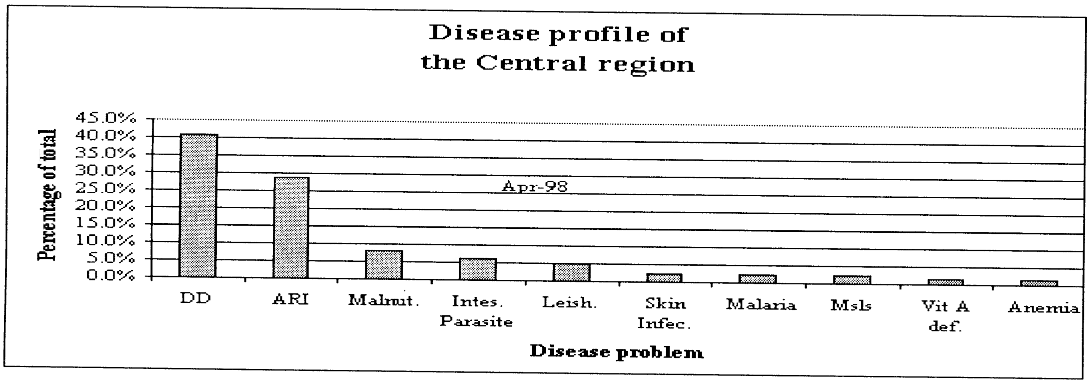
The provincial health profiles presented by the regional management teams have demonstrated a wide ranging level of organization and management of health services; human resources and their distribution; number of heath facilities by type and the package of services they provide; and availability and accessibility of primary health care services. In addition, these profiles give substantial evidence of the staggering mal-distribution of financial resources and of the supporting agencies at intra and inter-regional level. (Annex VI to X show the summary data on health facilities by type, location and the services they provide including segregated data on beds by gender and the distribution of human resources by category, location and by gender). Table 1 to 6 bellow provide summary of the leading causes of illness by region.

Table (1)



From the data presented, the patterns of disease profiles (incidence & prevalence rate) differ, but the burden of disease in terms of overall health status (morbidity, mortality and disability) appears similar among the five regions in which data was available. Nonetheless, there is evidence that communicable diseases such as tuberculosis, measles, polio, neonatal tetanus, malaria, diarrhoea, acute respiratory infections, and pneumonia remain a serious threat to the Afghan population, particularly to children and women. For example, 70% of the total tuberculosis cases are females of the reproductive age group (15-44 yrs).

Table (2)



The data on the disease profiles presented in the workshop, though incomplete, is all facility based. Maternal deaths and disabilities due to pregnancy and childbirth related causes are also unacceptably very high. Estimates demonstrate that less than 10% of mothers receive maternity care and around 9% of deliveries are attended by trained health workers.

Table (3)

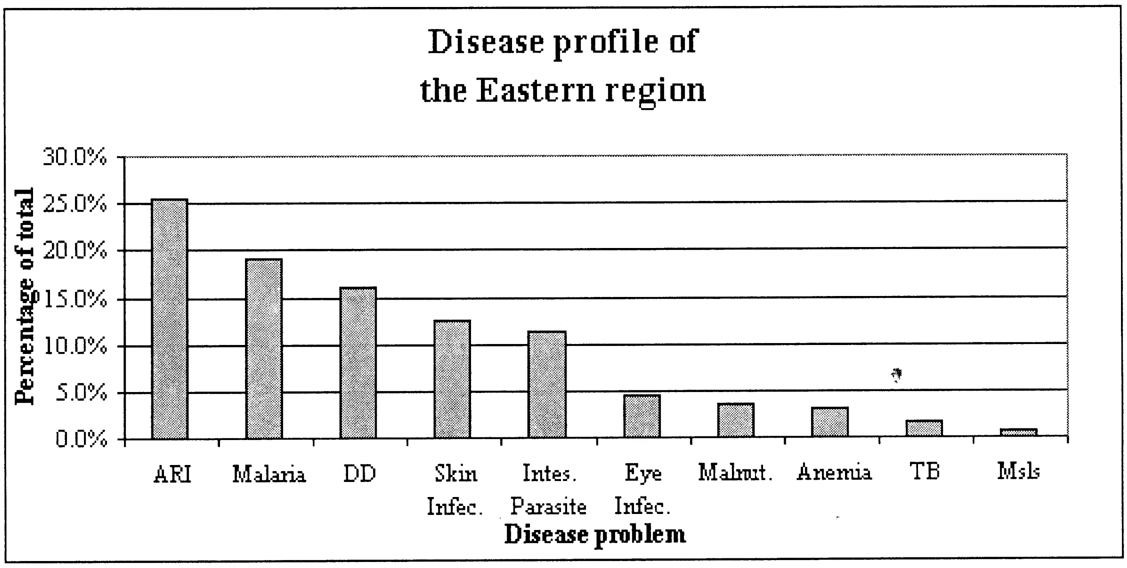
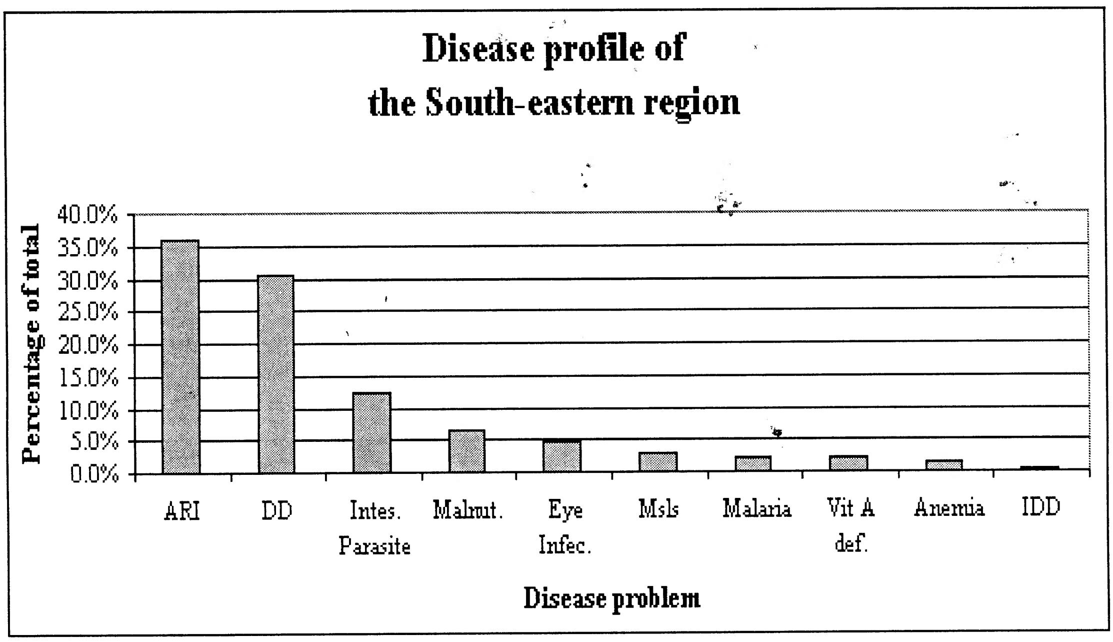


Table (4)



The above disease conditions affect mainly mothers (of 15-44 age groups) and children (under five). The irony is that the medical technology and knowledge to prevent and to treat the majority of the above health problems can be easily put in place in Afghanistan at an affordable cost.

Table (5)

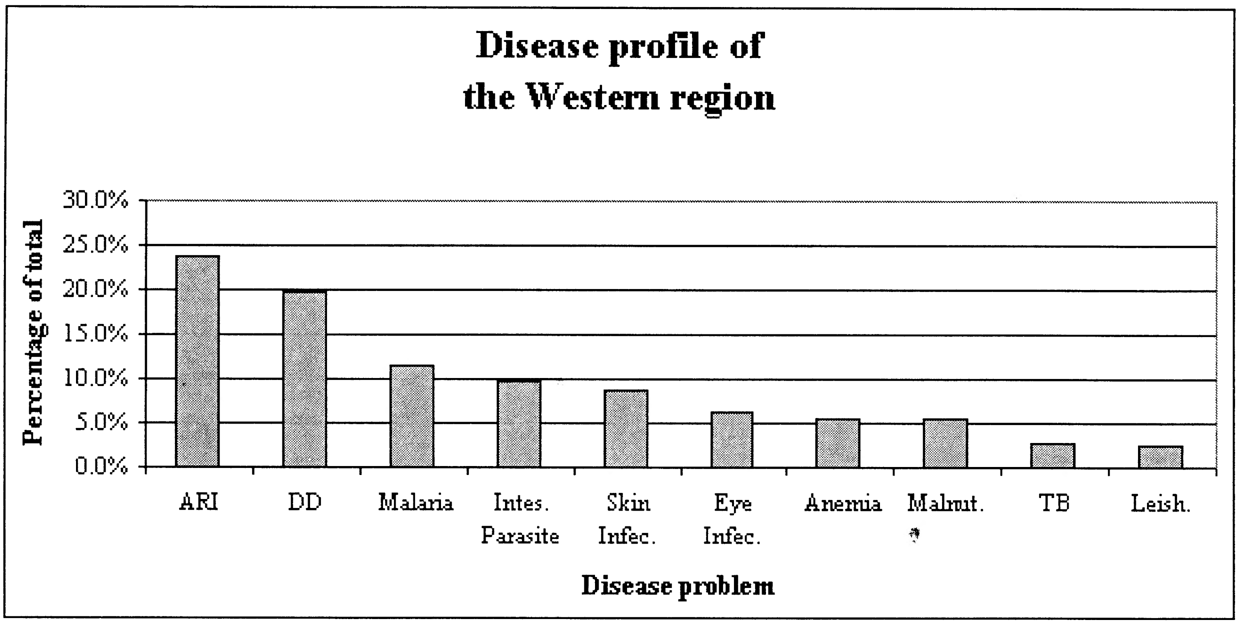
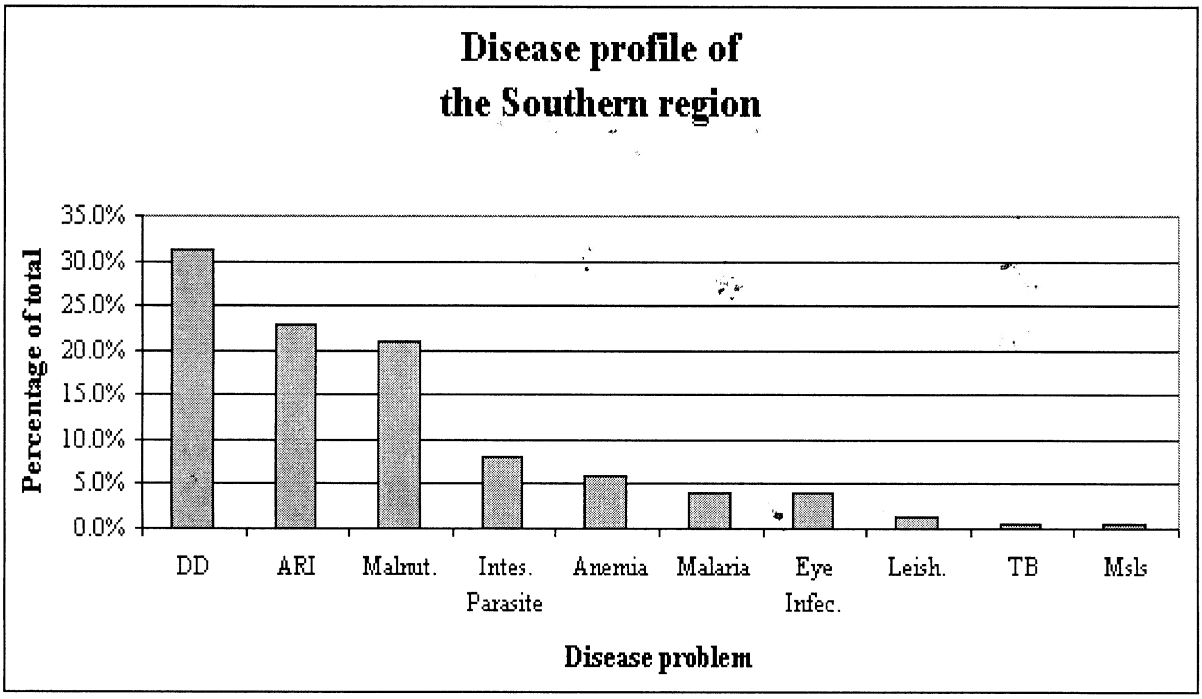


Table (6)



The health of any nation is determined by many factors. Demographic, socio-economic and environmental factors which constantly interact with human behaviour, values and practices and, are in turn, influenced by the health interventions, resulting into a specific health profile. Data on the social and economic indicators is sketchy, especially at the micro level. Table 7 below gives the national estimates of key demographic, socio-economic, health status, health services and human resources indicators in Afghanistan.

TABLE (7)
DEMOGRAPHY

Indicators	Year	Value	Reference
1. Number of provinces	1998		
Total		31	Afghanistan
N-East		4	Gazetteer
West		4	(government
North		5	of Afg.)
Centre		6	
South East		4	
South		5	
East		3	
2. Total area (in thousand sq. Km) and regional percentage out of the total area.			Afghanistan
Total		636.27 100%	
N-East		78.30 12%	Gazetteer
West		158.38 25%	(Government
North		76.46 12%	of Afg.)
Centre		47.74 8%	
South East		50.57 8%	
South		199.43 31%	
East		25.39 4%	
3. Population (in millions) and percentage of population by region	1998		Thomas
Total		20.05 100%	Eighmy 1990
North-East		3.11 15%	Afghanistan
West		2.37 12%	Population
North		3.03 15%	
Centre		4.82 24%	
South East		2.04 10%	
South		2.72 14%	
East		1.96 10%	
4. Population per sq. Km	1998		
Country		32	
N-East		40	
West		15	
North		40	
Centre		101	
South East		40	
South		14	
East		77	
5. Population growth rate (%)	1996	2.5	
6. Dependency ratio (ratio of dependent population %) (<15 years & >64 years)		49	
7. Urban population (in thousands) 25% of total population	1998	5,013	
8. Average family size	1988	6-7	
9. Total fertility rate	1995	6.2	
10. CBR(crude birth rate per 1000 population)	1995	48	
11. CDR(crude death rate per 1000 population)	1995	28	

Table (8)

Socio-Economic Indicators

Indicators	Year	Value	Reference
SOCIO-ECONOMIC ENVIRONMENT			
1. P. C. GNP (in US $)	1995	180	EMRO Demographic and Health indicators for countries in the EM Region, 1996.
2. Literacy			
2.1 Adult literacy Total(%)	1995	27	
2.2 Adult literacy males(%)	1995	45.2	
2.3 Adult literacy females(%)	1995	13.5	
2.4 School enrolment ratio – first level (%)	1995	18.0	
3. Life expectancy at birth			
3.1 Life expectancy Total(yrs)	1996	43.5	
3.2 Life expectancy males(yrs)	1996	43.0	
3.3 Life expectancy females(yrs)	1996	44	

Table (9)
HEALTH STATUS INDICATORS

Indicators	Year	Value	Reference
Mortality Rates:			
1. Maternal Mortality Rate (per 100,000 live births)	1996	1,700	WHO/UNICEF Pub. 1996
2. Under 5 Mortality Rate (per 1,000 live births)	1995	250	EMRO Demographic and Health indicators for EM regions, 1996.
3. Infant mortality rate (per 1,000 live births)	1995	165	
4. Low Birth weight (LBW) (% less than 2500 gr.)	1991	20	The five year Master plan, 1991
5. Acute malnutrition (Using Weight/height Index)	1997	14--35%	Unpublished data from Multiple indicator survey, 1997
Morbidity Rates:			
6. Incidence of TB per 100,000 population	1998	100 – 150	WHO REPORT, 1997
7. Cure rate of TB patients (%)	1996	66	WHO REPORT, 1997
8. Incidence of Malaria per 10,000 people	1995	1,500	WHO REPORT, 1997

Table (10)
HEALTH SERVICES COVERAGE

Indicators	Year	Value	Reference
1. Immunisation			
1.1 DPT3 (% infants immunised)	1997	45	WHO/UNICEF, AFG. Report 1998
1.2 Measles (% infants immunised)	1997	58	
1.3 OPV3 (% infants immunised)	1997	45	
1.4 BCG (% infants immunised)	1997	66	//
1.5 Tetanus (% of women in CBA immunised with at-least two doses of TT)	1997	9	//
1.7 Total no. of centres providing immunisations	1997	440	
2. Primary health care services			
2.1 % population covered (Total)	1997	35	Estimated by MOPH WHO/UNICEF, 1997
2.2 % population covered (Urban)	1997	55	
2.3 % population covered (Rural)	1997	25	

Indicators	Year	Value	Reference
3. MCH coverage by trained personnel of			
3.1 % of pregnant women receiving maternity care	1997	10	Estimates by MOPH, WHO AFG. 1997
3.2 % of deliveries attended by trained health personnel	1997	9	//
3.3 % of deliveries attended by trained TBAs.	1997	6	
4. No. Of hospitals' bed per 10,000 population	1998	3	
RESOURCES FOR HEALTH:			
5. Internal resources (% GNP spent on health)	1990	2.8	MOPH
6. Local health care (% health expenditure spent on PHC)	1990	37	//
HEALTH POLICY:			
7. HFA endorsement continues	1994	--	MOPH
8. Health system decentralisation and endorsement of the regional Primary Health Care Frame-work (eight regions)	1994	--	MOPH
9. % of population with safe water available in the home or with reasonable access:			
- Total	1999	10.3	Estimates by MOPH,
- Urban (water)		10.9	WHO, UNICEF
- Rural (water)		13.5	
10. % of population adequate excreta disposal facilities:			
- Total	1995	4.48	Estimates by MOPH,
- Urban (Sanit.)		4.48	WHO, UNICEF
- Rural (sanit.)			
INDICATORS FOR HUMAN RESOURCES	1997		Data gathered at
11. physicians per 10, 000 population	1997	1.1	the health sector
12. dentists per 10.000 population	1997	0.1	planning workshop
13. Pharmacist per 10.000 population	1997	0.2	held in Feb-Mar,
14. nurses per 10,000 population	1997	1.5	1998.
15. midwives per 10.000 population	1997	0.3	
16. lab-technician per 10.000 population	1997	0.3	
17. vaccinators per 10.000 population	1997	0.4	
18. x-ray technicians	1997	0.1	

Available information on population covered by the existing primary health care services is inadequate and, hence, is difficult to measure. However, estimates indicate that around 40% of the total population in the entire country, including the five regions, which participated in the planning exercise, have less than desirable access to basic health care. Public health programmes such as immunisation, malaria, control of diarrhoeal diseases and of respiratory infections as well as water and sanitation programmes have made some progress in terms of coverage and impact, particularly in the last three years. Similarly, the tertiary health care, particularly at major regional centres such as Herat, Kandahar, Jalalabad and Kabul have seen reasonable improvement due to substantial input (technical, material and financial resources) from the international community in the last two years. It is, however, clear that the expansion of the health care to more districts has not produced the desired outcome in terms of increase in provision of primary health care services on a continuing basis. This is mainly due to poor health management support systems, logistic problems, general lack of local resources and insecurity.

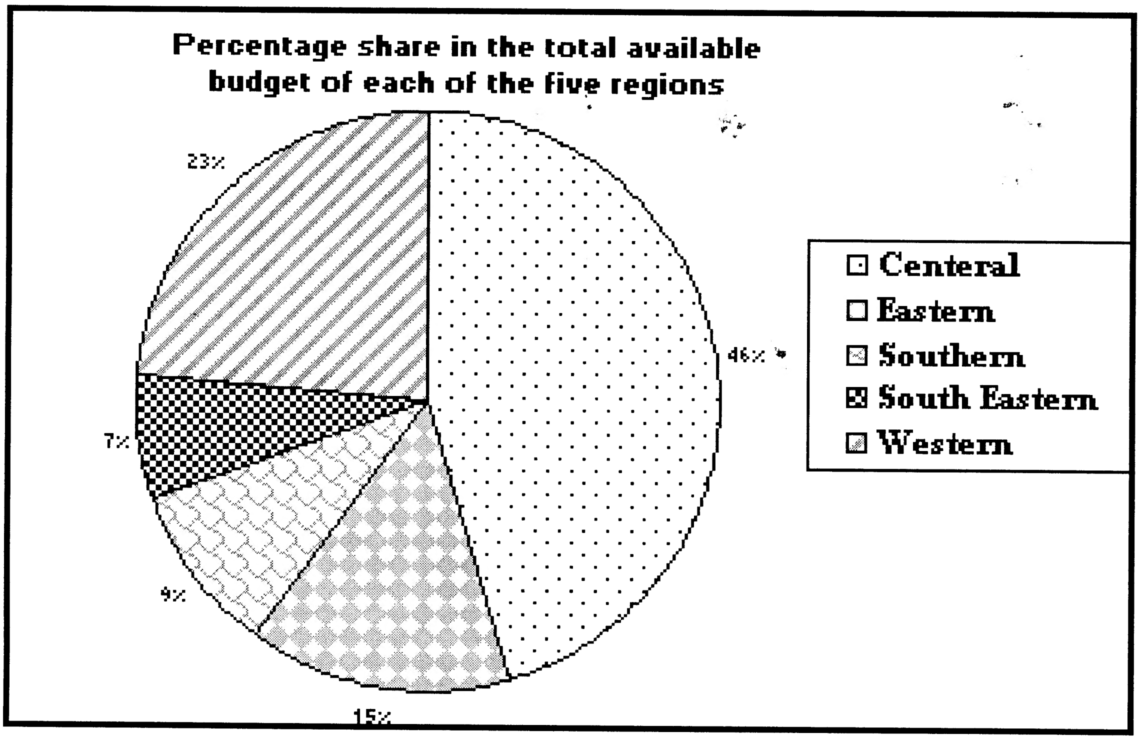
There is strong evidence that the international aid community's support (technical, material and financial) to the health sector of Afghanistan is becoming increasingly significant and is likely to play a major role in the rehabilitation of the health system in Afghanistan. Some estimates suggest that the international community meet around 60% of the health expenditure. This clearly raises the question of financial sustainability of the ongoing programs and projects.

The need for a workable exit strategy and smooth hand over of programme responsibilities to local authorities, who are prepared to shoulder the financial, organisational and management responsibilities of programmes, was emphasised during the planning workshop. The participants also discussed ways and means of mobilising local resources through cost sharing mechanisms. To this end, the participants agreed on a recommendation calling for further studies on the present situation of the health care financing in Afghanistan. The participants also stressed the need for developing policies and strategies on cost sharing.

Data on the financial resources allocated to the various activities in each of the five regions, namely Eastern, South-eastern, Southern, Western and Central regions for the year 1998 shows that 46% of all available resources (out of a total available budget of US$ 15,996,438) has been allocated to the central region, mainly to the Kabul city. The allocations to the other four regions are given below. Diagram 1 to 6 below show the financial distribution by region and by main stakeholders in each region.

- Western region: 23%
- Southern region: 9%
- Eastern region: 15% and
- South-eastern region: 7%

Diagram (1)



The above budget figures do not reflect the total available health expenditure for 1998, as several organisations, both local and international, could not determine or provide the financial information of their activities at the time of the workshop. It was all too evident that serious and unacceptable disparities in financial resource allocations exist at inter-regional as well as the intra-regional levels. The workshop participants have agreed to study and resolve the current situation.

Diagram (2)

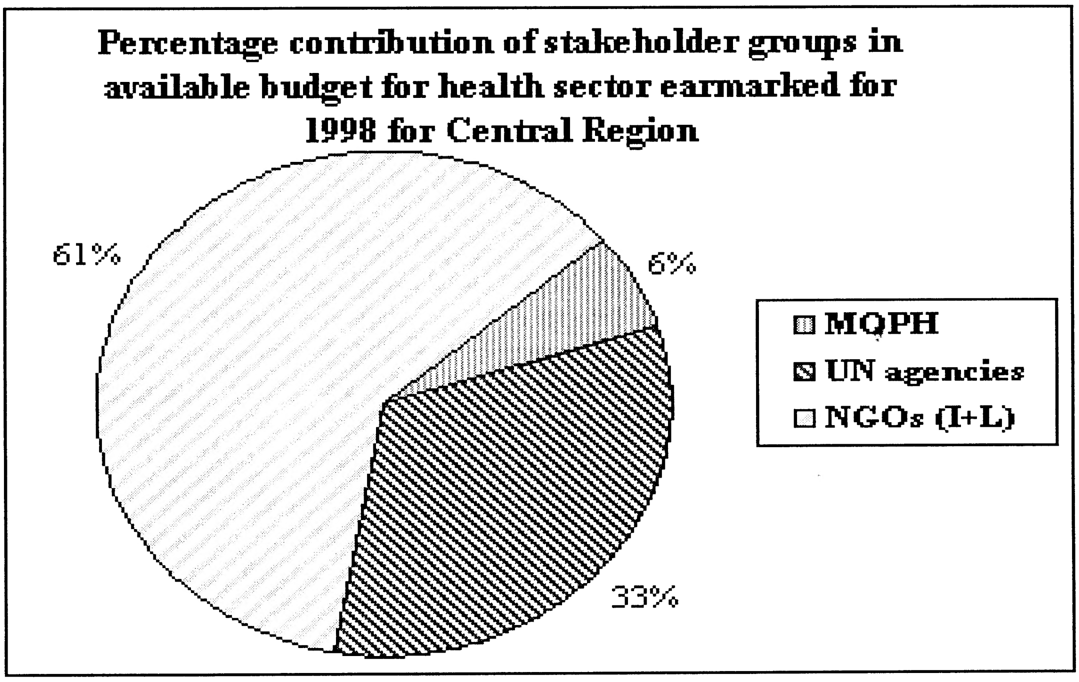


Diagram (3)

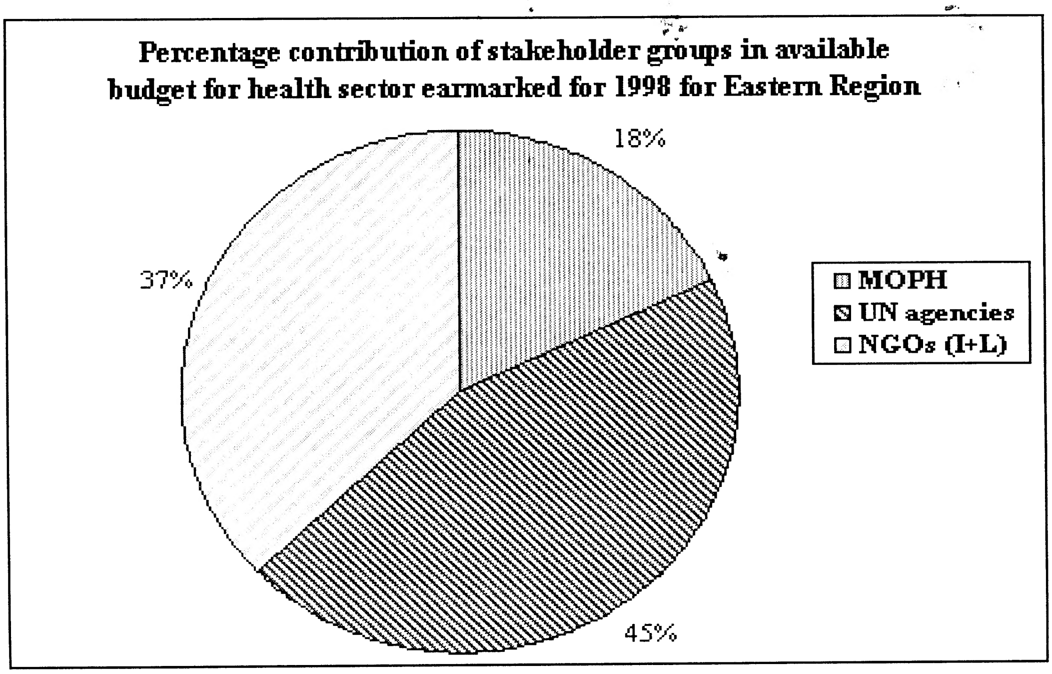


Diagram (4)

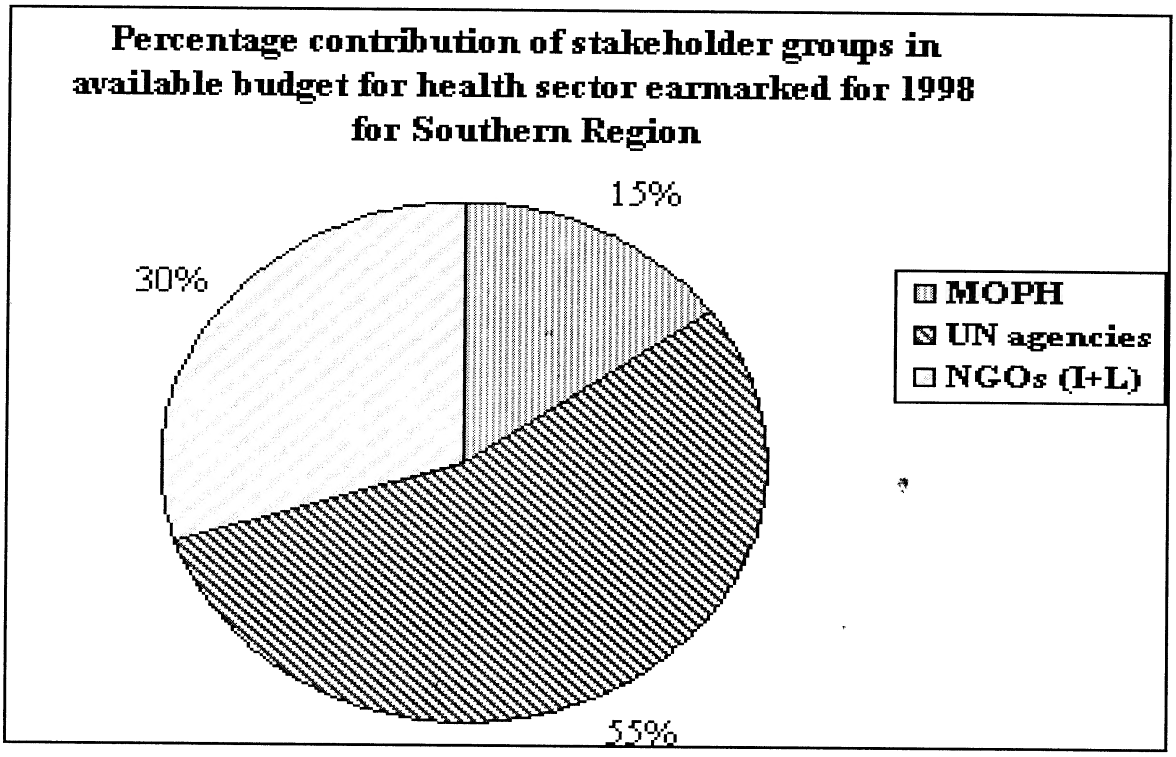
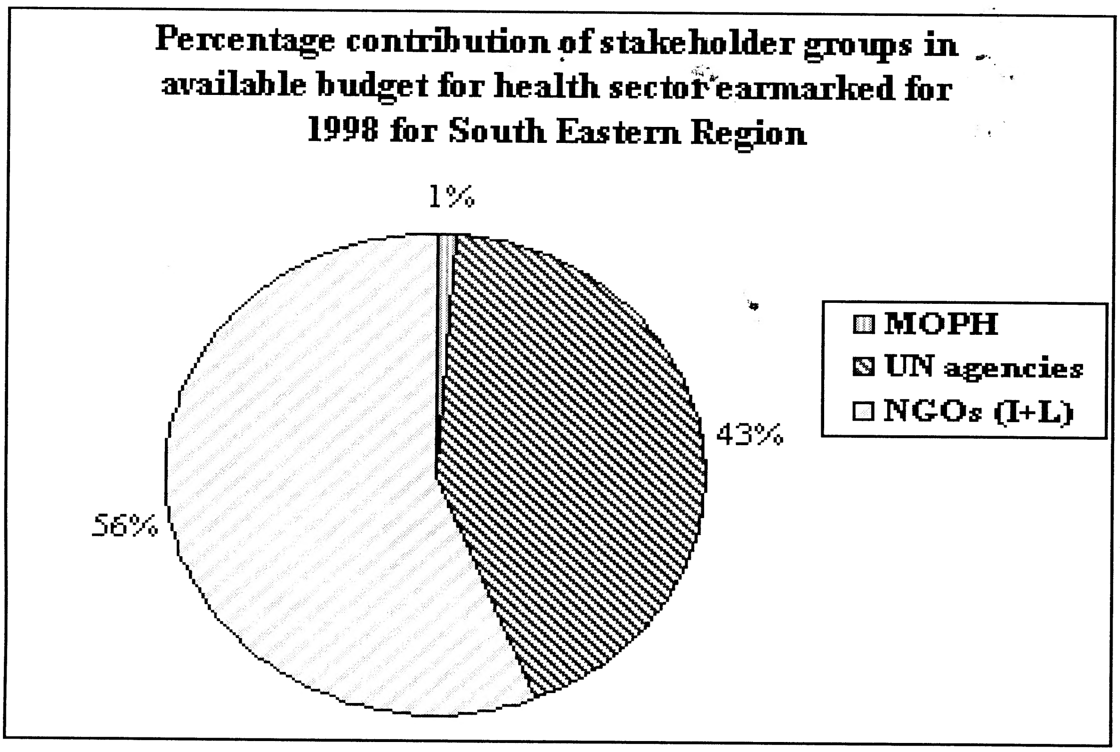


Diagram (5)



Preface

The World Health Organization (WHO) in collaboration with the Ministry of Public Health, UNICEF and the NGOs has been pursuing the implementation of a decentralised Primary Health Care strategy in Afghanistan. As part of this strategy the country has been operationally divided into seven regions. Each region has a varying number of provinces (see Afghanistan Map). To operationalize the concept of decentralizations, the Ministry of Public Health has established Regional Public Health Directorates and Regional Health Management Teams (RHMT). In some provinces Provincial Health Management Teams (PHMT) are also set-up.[1] This re-structuring process of management of health programmes was started in 1994 and is still continuing. Progress towards its institutionalisation and consolidation has been slow due to the ongoing civil war and shortage of resources.

Central to the process of decentralisation is the aim to create a local technical and management capacity with skills and professional staff who can identify, plan and manage health resources, to respond to local health needs, improve the access to, and quality of, health services in a more equitable and efficient way through people-centred policy frameworks.

One of the long-term goals of WHO in Afghanistan is to promote community participation and a greater degree of self-reliance under the Basic Development Needs (BDN) Approach. To achieve this goal WHO has designed the strategy which focuses on the establishment of local health committees, using the existing local structures at grassroots level, i.e. SHURA system. As part of the strategy these local health committees will have broad-based participation of the local population and their institutional capacity will be built so that they become effective and democratic agency of change at the micro level having strong networking amongst themselves and good coordination with MOPH and other relevant authorities working under a complete decentralised mode of management.

The health sector planning workshop was an important milestone in this process, attended by people from peripheral to central level of the health care structure. The workshop provided an opportunity to all to reflect on the collective efforts of all stakeholders in the health sector, and later translated their assessments and judgements into a common set of health priorities, targets, and a plan for judicious use of the available resources.

The most important products of the workshop are the five regional work-plans for 1998, and development of five comprehensive regional health profiles which give for the first time a fairly complete picture of the existing health resources (health personnel by category and health facilities by type and location), and the regional disease profiles. A pre-planning workshop at each of the five regions was held to ensure maximum participation of peripheral levels of the structures of health agencies, including MOPH, NGOs and the UN to share the key achievements of their respective organisations against the defined objectives for 1997, and also make a critical assessment of the health situation of their respective regions, as well as discuss and agree on health intervention priorities for 1998. The pre-planning workshops were followed by a planning workshop in Kabul held from February 15 to March 2, 1998, participated by 41 NGOs, 4 UN agencies and MOPH personnel from 20 provinces. Given the security and extreme weather and natural conditions of the context, it was not

1 . It must be noted here that confusion is often made regarding RHMTs/PHMTs and Regional Health Coordination Committees (RHCCs). While the former are an integral part of the MOPH structure, the latter is an inter-agency mechanism to promote coordination and technical cooperation among the stakeholders of health sector representing international aid community, indigenous NGOs, MOPH, donors and in some cases community members as well.

Diagram (6)

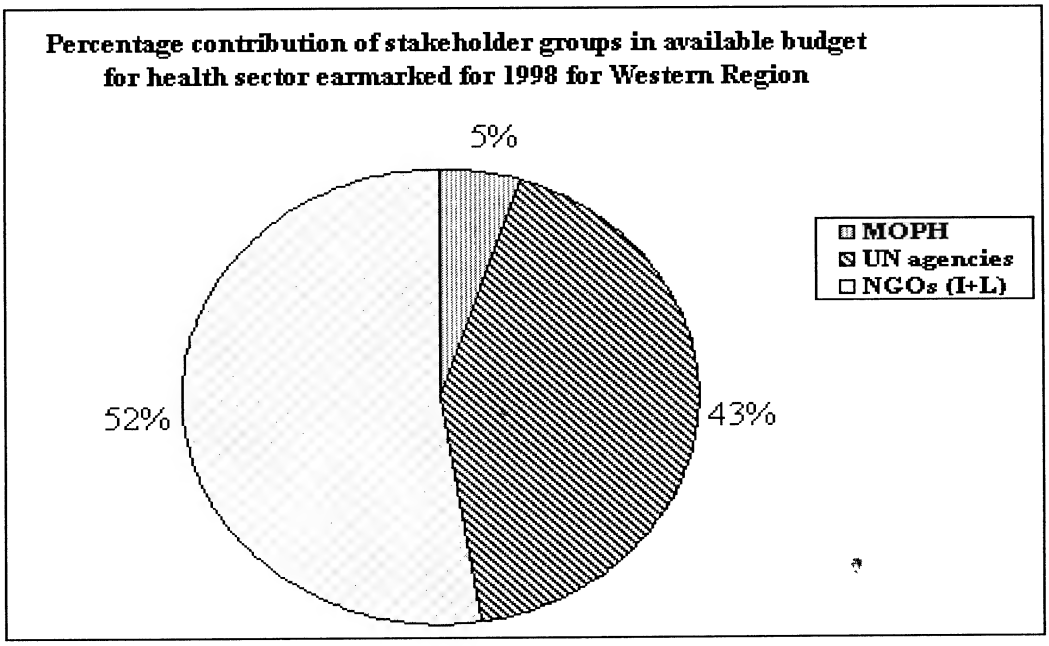


Diagram (7) presents percentage of 1998 available budget by the programming areas in all five regions.

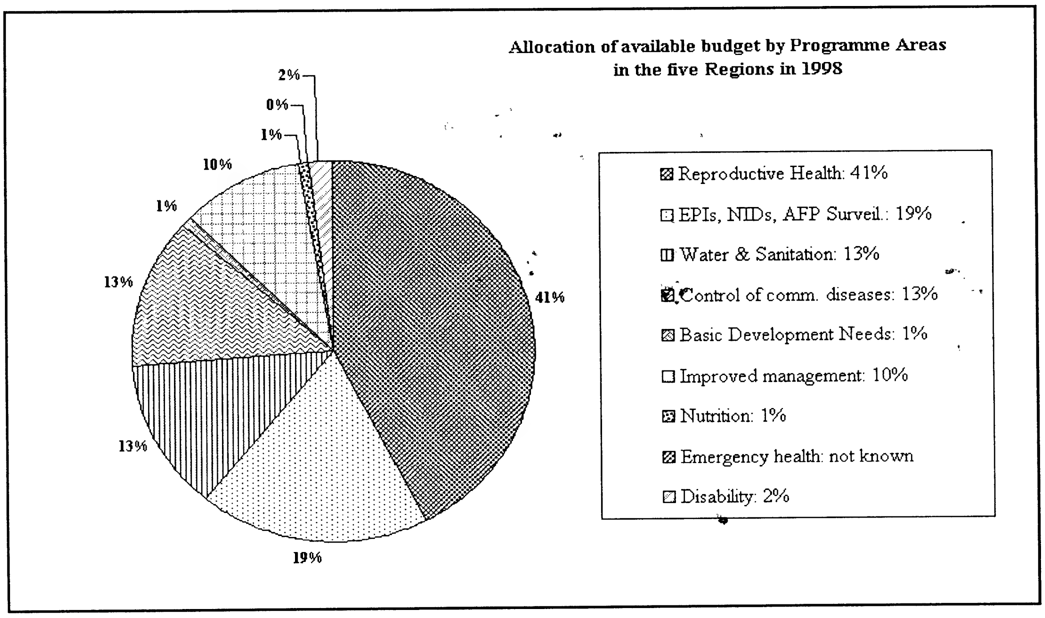


Table 11 to 15 bellow, present the allocation of total, available, and not available budget (1998) by programming areas in each of the five regions. It is pertinent here to mention that the priorities identified by each regional team were the same, i.e. reduction of maternal and under five children mortality and morbidity rate as well as improvement in the existing management capacities of the health sector, with the exception of disability as one of the four priorities of the southern region.

Improved management includes activities such as installation of health information systems, development of job descriptions, streamlining the policies, development of monitoring and

evaluation skills and systems, standardisation of cost-sharing and incentives, etc. Each region, however, developed their intervention strategies from such programme areas which they agreed were the most appropriate, cost efficient and potentially effective. These include programme areas shown in diagram 7 above. As evident from table 11 to 15, each region has allocated different amounts against the key programme areas for 1998. However, it is critical to emphasise that each of the programme is designed to address the three key priorities for 1998. To ensure this, each work-plan has in-built monitoring indicators to assess the impact of these programmes on maternal and under five mortality and morbidity rate as well as on the management capacity.

Data presented in table 11 to 15 show programme areas share in the regional level total, available and not available budget.

Table (11)

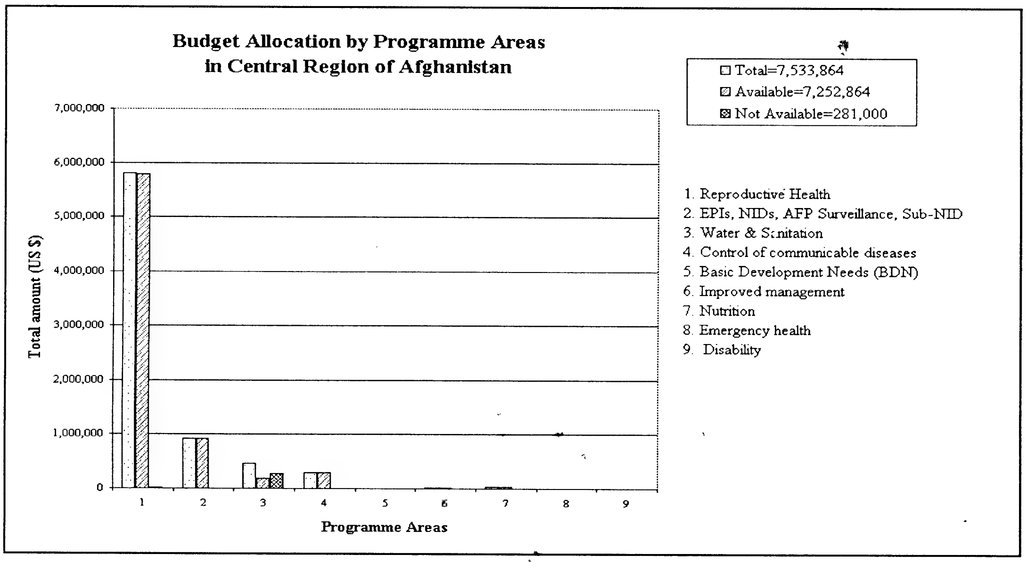


Table (12)

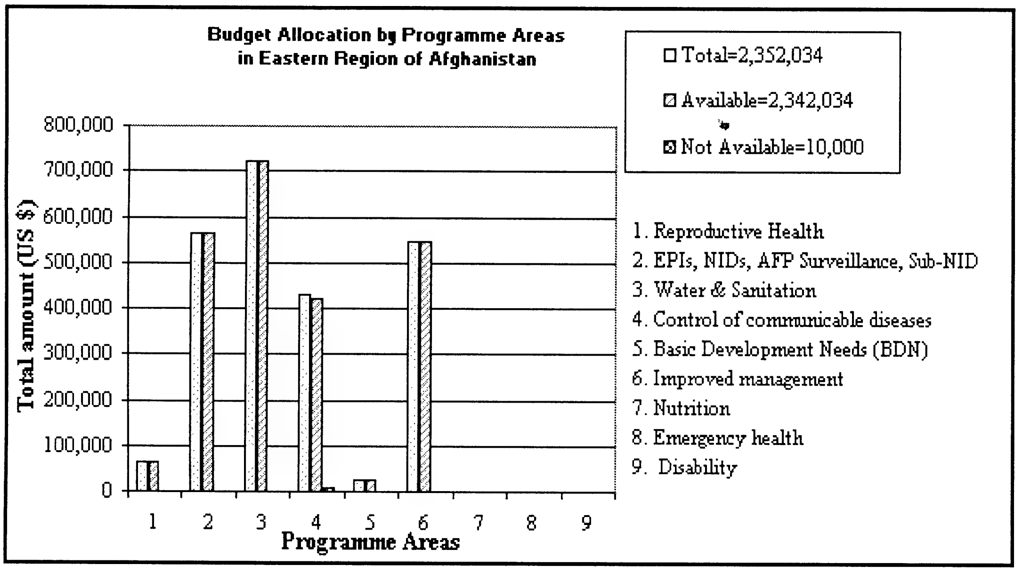


Table (13)

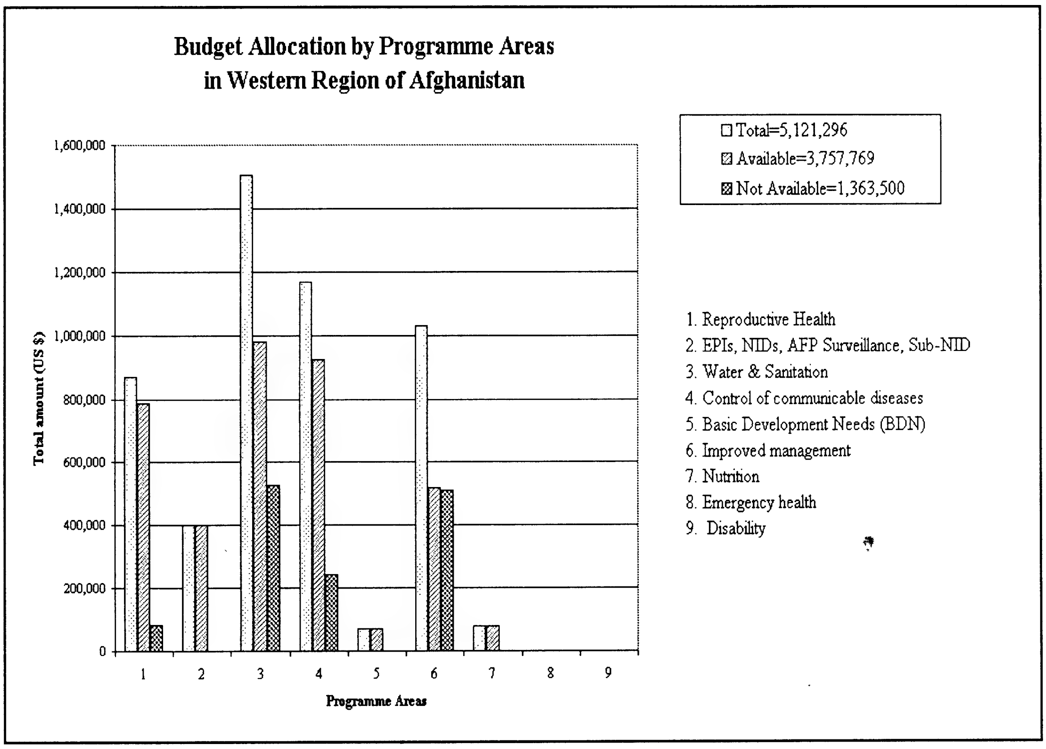


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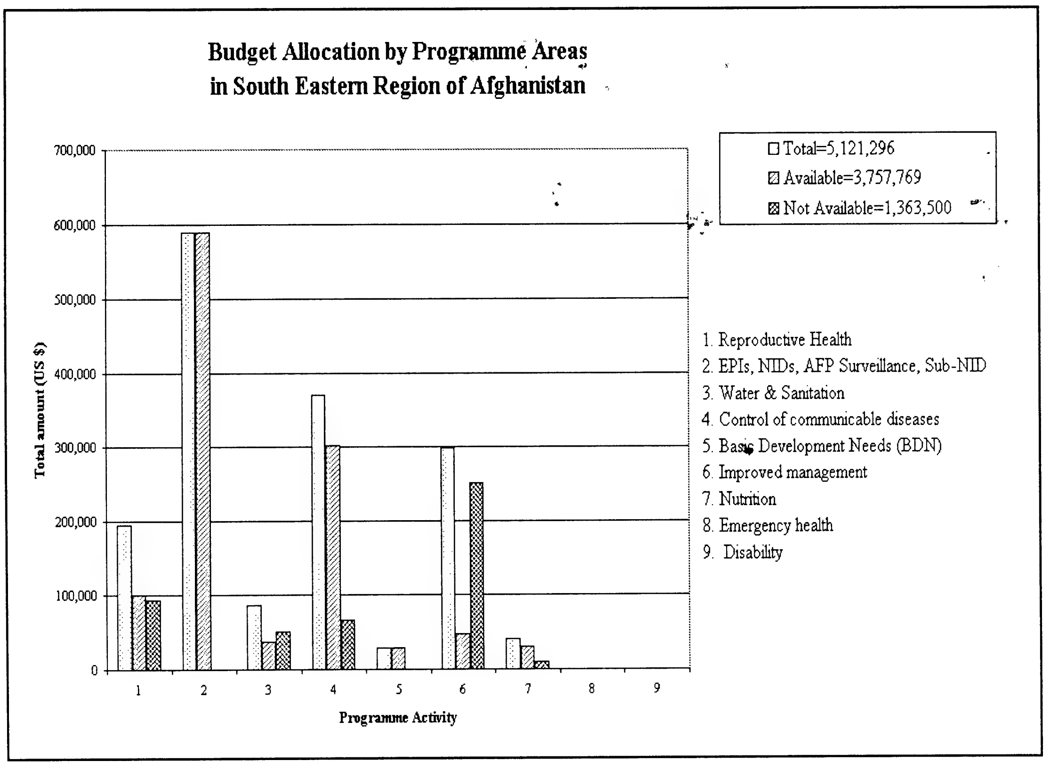


Table (15)

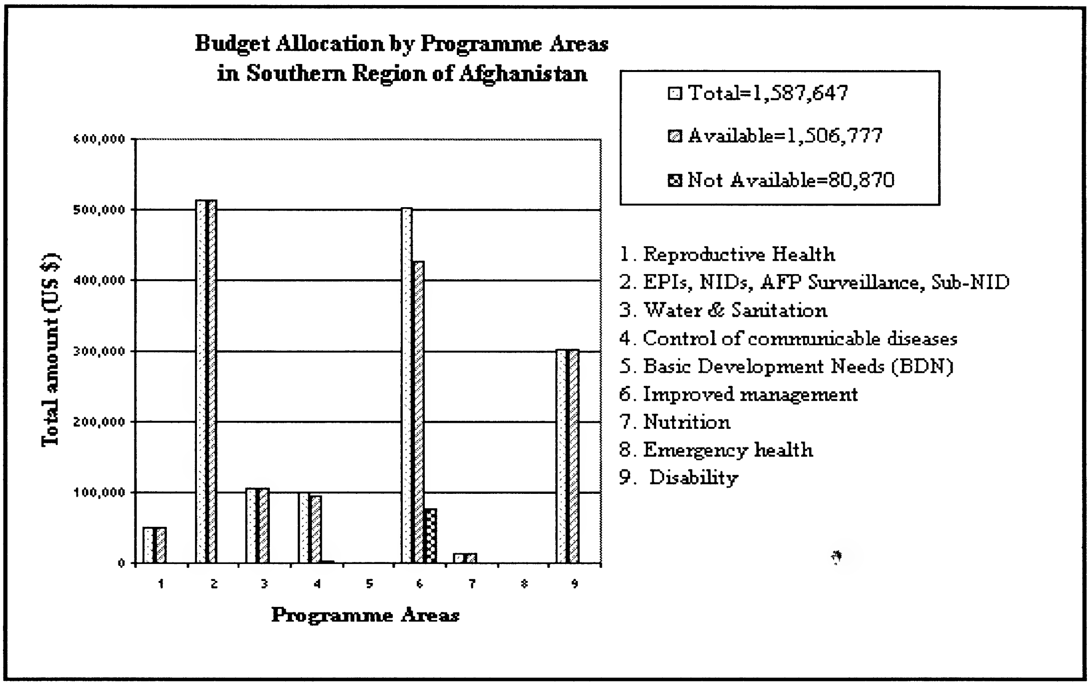
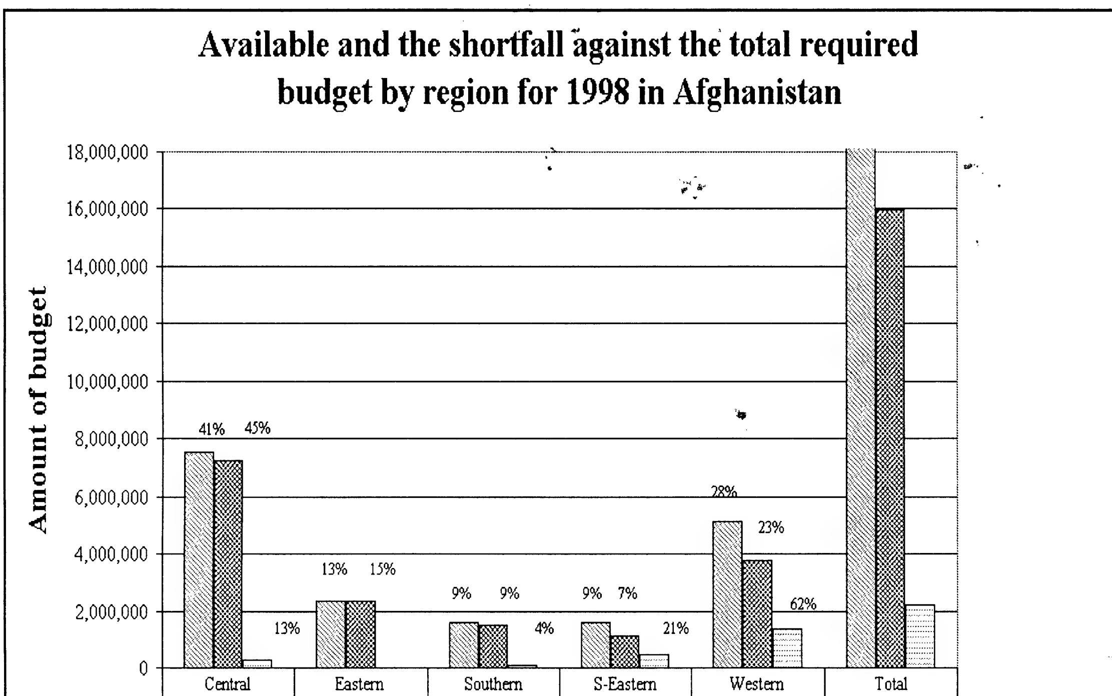


Table 16 bellow gives details of the budget shortfall as well as the available amount against the total budget required in each of the five regions for 1998.

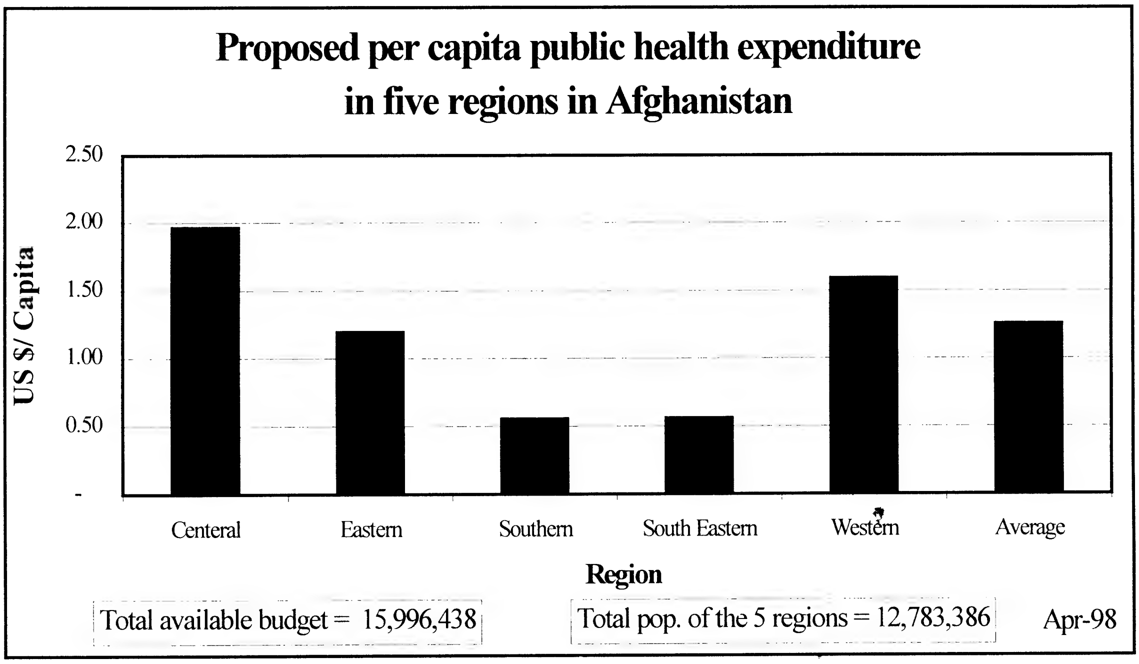
Table (16).



	Central	Eastern	Southern	S-Eastern	Western	Total
Total	7,533,864	2,352,034	1,587,647	1,610,727	5,121,296	18,205,568
Available	7,252,864	2,342,034	1,506,777	1,136,967	3,757,796	15,996,438
Not Avail.	281,000	10,000	80,870	473,760	1,363,500	2,209,130

Table 17 shows the proposed per capita expenditure by region for 1998.

Table (17)



Although data on the private health sector and expenditure were not available, however, there is strong indication that over the last two decades this sector has been developing itself in the scale of its operations as well as the diversity of services covered under it, and is, indeed, expanding as an important health care provider and stakeholder. The data presented in the workshop indicates that there are 187 private clinics in the five regions covered in the workshop. It is estimated that only 5 to 10 percent of the total population, mainly urban based, from these five regions, has access to the private health facilities. High cost and the urban location of most of the private services make them inaccessible for the vast majority of the people who are either poor or living below the poverty line. Besides the private clinics, there are also 2,596 private pharmacies in the five regions.

Table (18)

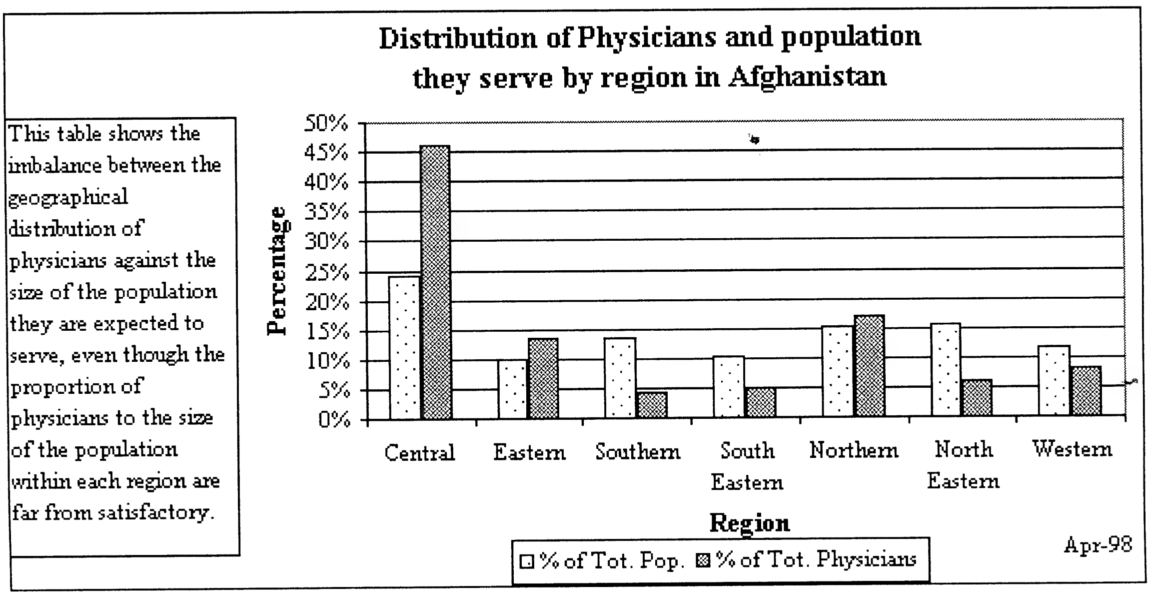
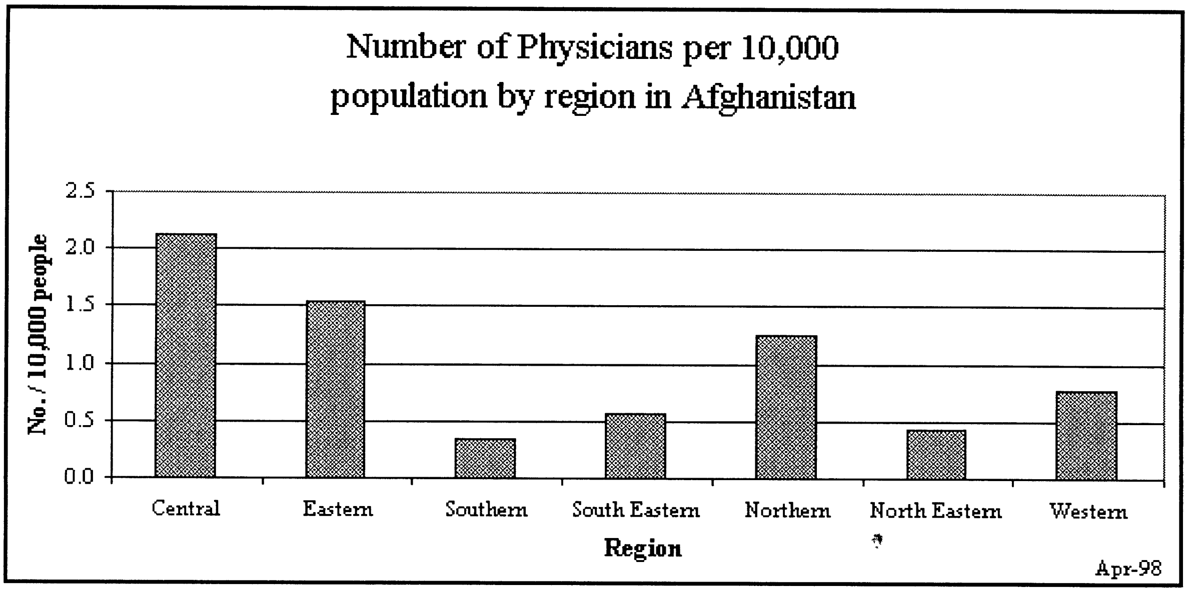
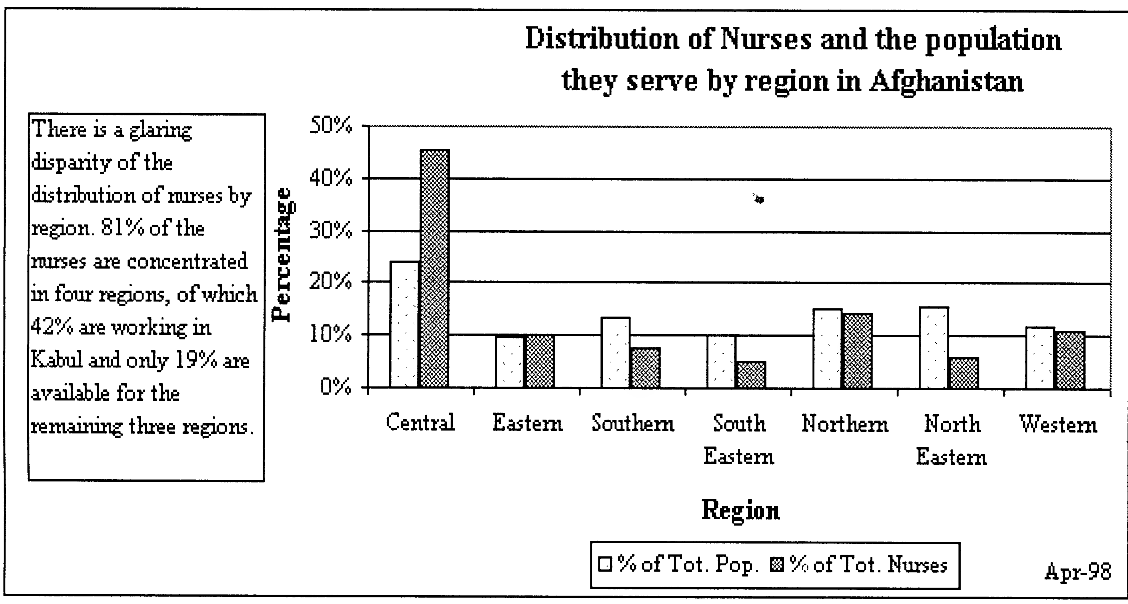


Table (19)



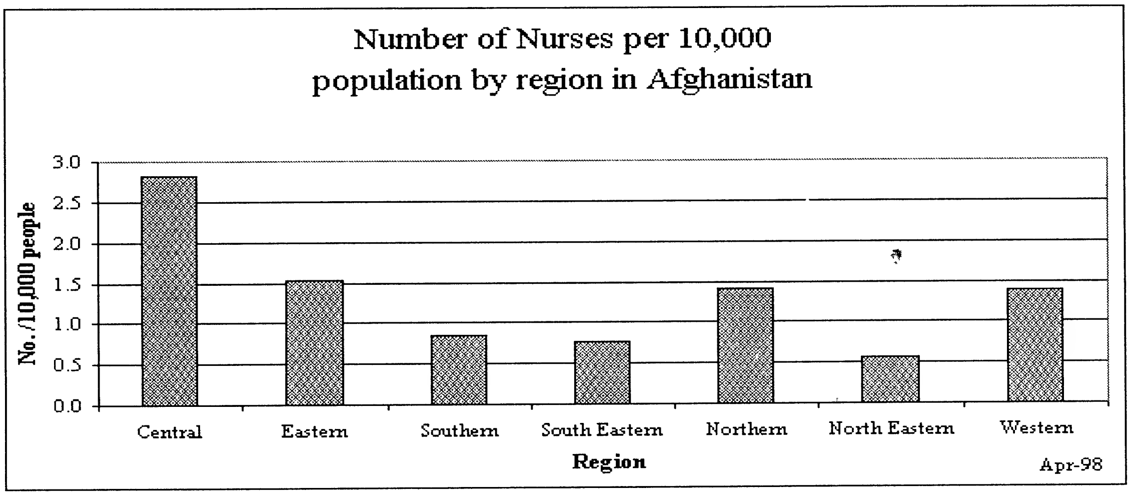
Available data shows that in Afghanistan at present, there are 2,228 physicians, 2,976 nurses, 654 midwives, 135 dentists, 755 vaccinators, 572 laboratory technicians, 218 x-ray technicians, 335 pharmacists and 4,491 other categories of health workers (including Mid-level and basic health workers, sanitarians, auxiliaries, field microscopists, village health volunteers-VHVs, traditional birth attendants, administrative and support staff). This gives a health worker population ratio of 1.1 physician per 10,000 population, 1.5 nurses per 10,000 population, 0.3 midwives per 10,000 population, 0.1 dentist per 10,000 population, 0.4 vaccinator per 10,000 population, 0.3 laboratory technicians per 10,000 population, 0.1 x-ray technician per 10,000 population, 0.2 pharmacists per 10,000 population.

Table (20)



Afghanistan health sector is facing serious imbalances in its workforce in terms of even, fair and equitable distribution on geographical and population basis. The other related problem is the very low productivity associated mainly to poor working conditions, low morale of the staff, low and irregular salaries, limited career opportunities, limited professional growth opportunities, unclarity regarding job descriptions, high turn over of the staff, frequent shuffling of the staff across the regions, steady loss of trained human capital in the health sector due to the protracted conflict and economic instability.

Table (21)



As a consequence, there is a staggering mal-distribution of health providers and personnel within the regions and provinces. For example, of the total physicians 66% of them and 66% of the total nurses are concentrated mainly in the provincial capitals of four provinces namely Kabul, Nangarhar, Balkh, and Herat. Forty-two percent of the nurses and 40% of the physicians are in Kabul. About 34% of the physicians and 34% of the nurses are available for the remaining 27 provinces to serve a total population of about 14.5 million. The planning workshop discussed this issue and made recommendation for rational redistribution of existing health personnel. The Ministry of Health has taken a keen interest in addressing this issue.

The following tables (22 to 24) illustrate the distribution of health human resources (from reproductive health care) in the five regions covered in the planning workshop and their proportionate ratio against the population coverage.

Table (22)

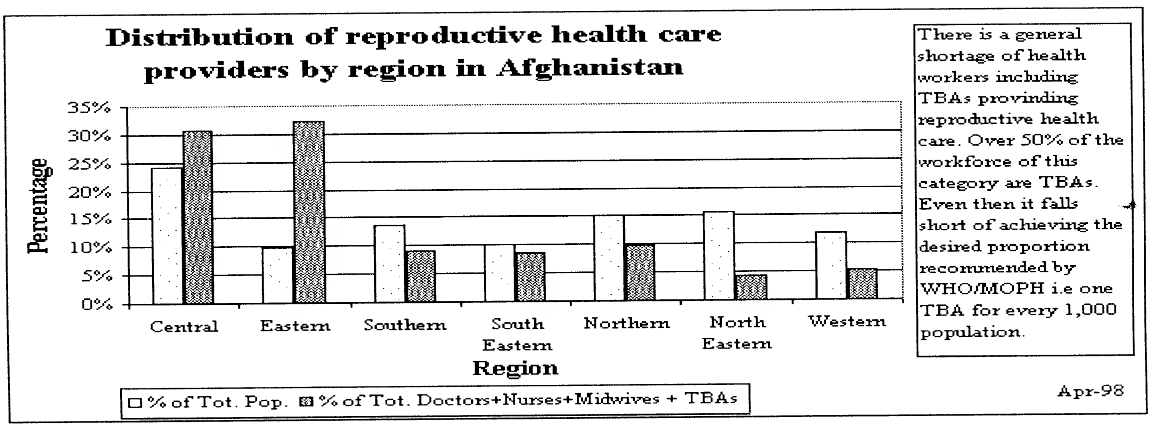


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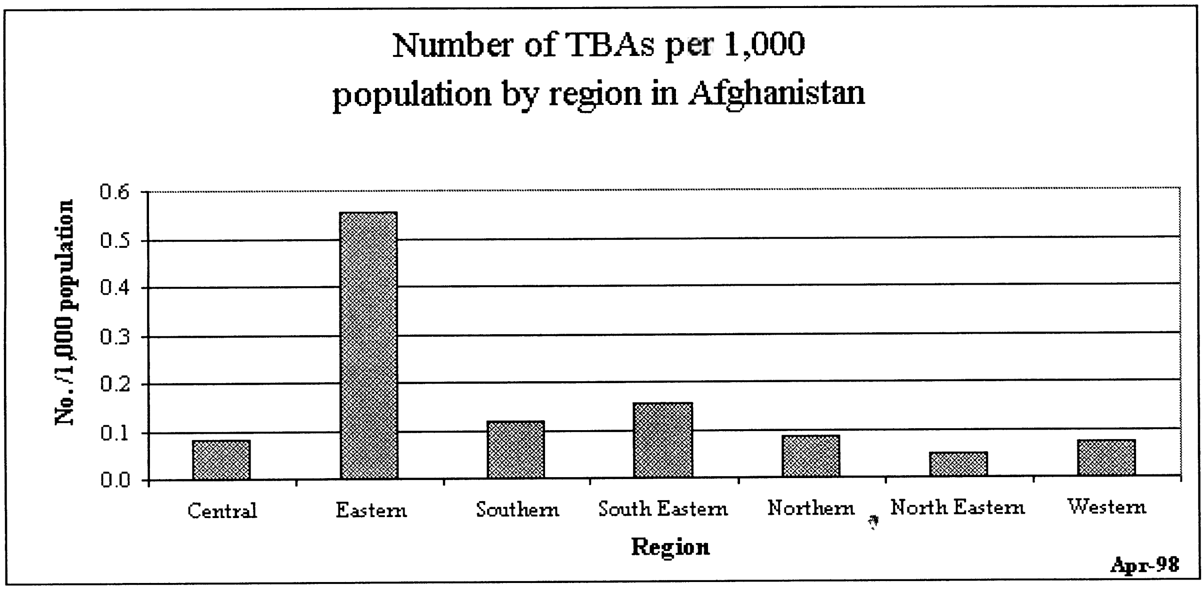
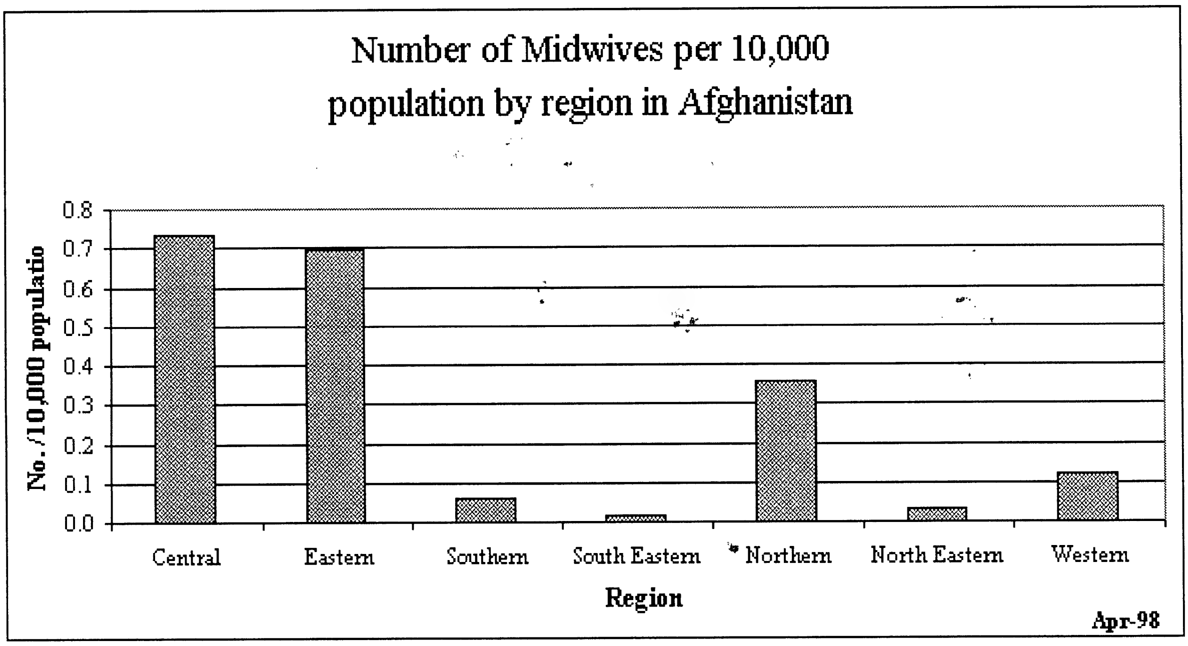
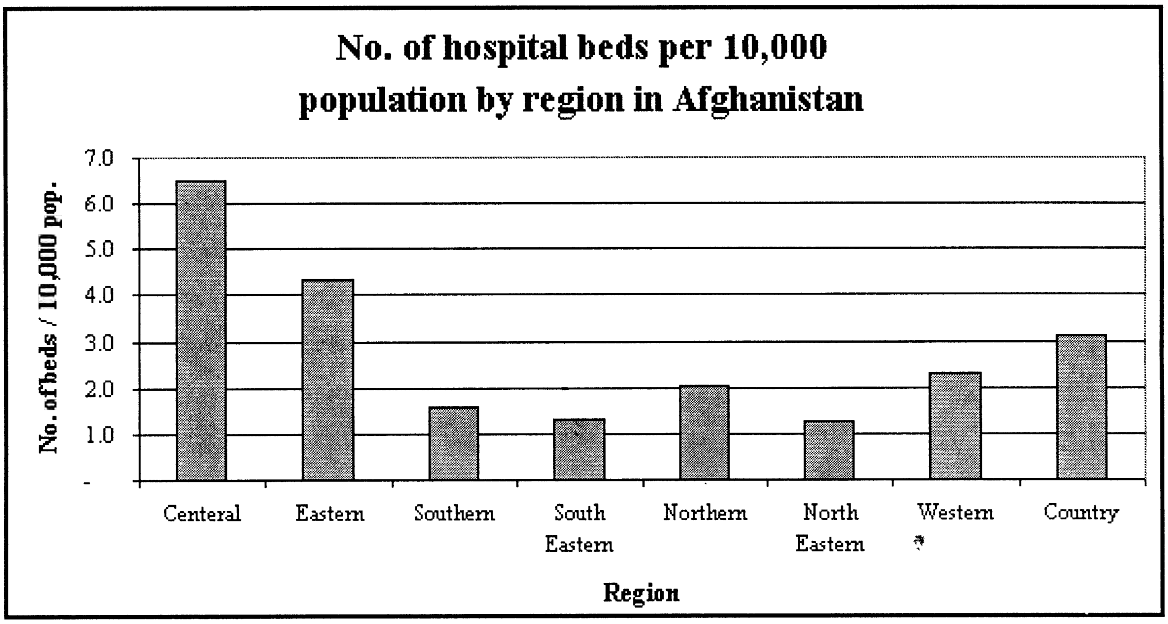


Table (24)



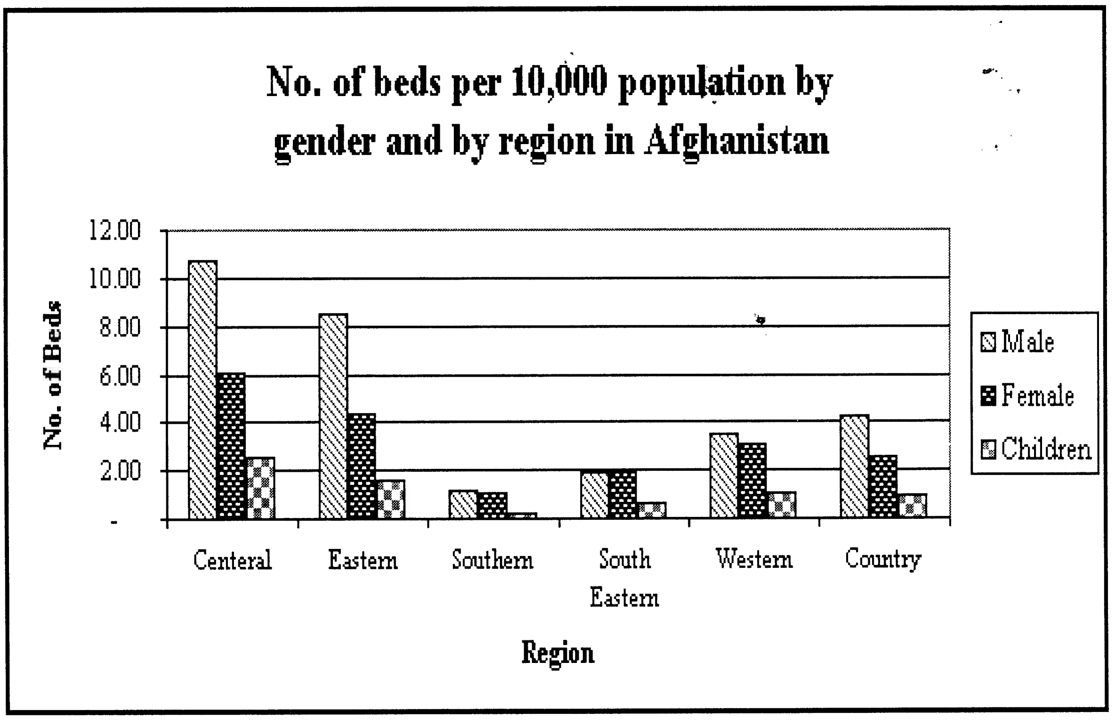
From the above data it is clear that there is widespread general shortage of health personnel. In particular there is a chronic dearth of nurses, midwives, dentists, pharmacists and vaccinators. The mal-distribution of the existing health personnel remains one of the major problems facing the health sector. This is further compounded by the lack of salaries, low pay when it is available, and lack of career opportunities leading to lack of staff motivation, low performance and hence low productivity.

Table (25)



Of the 6,246 beds in the whole of Afghanistan, 50% are located in the central region, out of which 90% are in Kabul City alone. This gives a ratio of 11.2 beds per 10,000 population in Kabul City against a ratio of 2 per 10,000 population for the rest of the country. Table 25 (above) and table 26 (bellow) provide data on number of beds per 10,000 population by region as well as number of beds broken down by age and sex per 10,000 population by region. For further details see annex VI to X.

Table (26)



6. MONITORING AND EVALUATION PROCEDURES

Monitoring and evaluation of health programmes in Afghanistan have always been very poor. However, WHO's investment and the concerted efforts over the last several years to facilitate development of its local counterpart technical capacity that can monitor and evaluate progress towards achieving programme targets has started resulting in monitoring and evaluation carried out by RHMTs and PHMTs of MOPH. More training and resources will be required to ensure further strengthening of these capacities of health sector for better supervision of programme performance through a regular monitoring and evaluation system as well as of the impact assessment of outputs.

Through the planning process, and as an integral part of workplans, an in-build mechanism for monitoring and evaluation of programme objectives and targets has been developed. For the first time, Regional and Provincial Health Management Teams are entrusted with the responsibility to conduct this task. The workshop participants have produced SMART[7] indicators to monitor the progress of the programmes and projects designed for 1998. They have also identified some means of verification for each of the indicators. Central to this entire process is the assessment thus done of the pace, quality and scale of the change which is expected to come in the people's health status during and at the end of the implementation of the work-plan by achieving the planned outputs and the immediate objectives set for 1998.

The regular monitoring will be carried out jointly by the implementing agency's programme staff and the relevant MOPH personnel, and where possible involving user groups. The later, for instance, is advisable for mothers users groups who are benefiting from MCH services, as well as rural and urban communities benefiting from water and sanitation programme and health education initiatives. The main concept here is to develop a sense of shared ownership and responsibility amongst the health care providers and the users/beneficiaries of the health care.

To assess the degree of our achievement towards this end, each of the workplan has built-in a mid-year review of their progress to be conducted in August 1998. This exercise should give us an opportunity to undertake a collective, open and transparent assessment of the facilitating and impinging factors as regards making a reality of the basic principles of regular monitoring as well as those effecting the planned interventions.

One area, which was identified jointly in the workshop is the need for building capacity of the implementing and supporting agencies in documentation of the monitoring process. It is suggested that at some later stage WHO with other partners may organise a workshop for health stakeholder staff for this purpose, and produce formats as well as guidelines for the documentation of monitoring and impact assessment.

[7]. Simple, measurable, accurate, reliable, and time-bound indicators.

possible to include North and North Eastern regions in the final planning workshop. However, the health infrastructure data presented in the report includes also the Northern and North Eastern regions and Bamyan province to present a national picture. The data from these regions and provinces was collected in early 1997. We are, however, aware of the difficulties of the current circumstances and its effect on the data collection process, which generated the information, included in this report and, thus, acknowledge the limitations in terms of the degree of validity and accuracy of the data. As the readers will find, the common thread running through this report is the critical and urgent need for reliable and updated health data as baseline to make realistic assessment, prioritisation, planning and to measure the impact of our collective interventions on the health status of Afghan women, children and men.

The workshop participants also deliberated on major issues of common concern shared by all stakeholders and have agreed on a number of recommendations for their resolution. These recommendations are included in this report. It is the collective responsibility of all the stakeholders of the health sector in Afghanistan to ensure that these recommendations get translated in concrete actions by the concerned authorities within the stipulated timeframe.

I am pleased to present to you the report of this important workshop, which was the result of over four month efforts by the World Health Organization and its partners in the health sector in Afghanistan. The workshop was made possible with the financial contribution of MoPH, WHO and UNICEF.

Finally, I wish to thank the Ministry of Public Health without whose leadership and dedication this workshop probably would not have met the same success. I also wish to thank my colleagues in the United Nations System, particularly the United Nations Children's Fund (UNICEF), a key partner in the health sector of Afghanistan, the NGOs community and the Donors for their support and encouragement.

Our motto remains ***HEALTH FOR ALL***.

Dr. Ashour. O Gebreel
WHO Representative
Afghanistan
April 29, 1998

SUMMARY OF THE ACTION PLAN OF CENTRAL REGION FOR 1998

1. REGION: Central

1.1 No. of provinces in region: 6: Kabul, Wardak, Logar, Kapisa, Parwan, Bamyan

1.2 No. of districts in region: 54: Kabul 14, Wardak 9, Logar 6, Kapisa 9, Parwan 9, Bamyan 7

1.3 No. of villages in region: 2425: Kabul 338, Wardak 687, Logar 272, Kapisa 479, Parwan 372, Bamyan 277

1.4 Total population: 4,824,470: Kabul 2,519,944 Wardak 441,427 Logar 324,967 Kapisa 519,483 Parwan 615,236, Bamyan 403,412

1.5 Population of each of the following categories and their respective percentage in total population:

CBAF 15-45: 901,211/18.68% FEMALE 5-14: 654,198/13.56% FEMALE 1-5: 323,239/6.70% FEMALE 0-1:78,639/1.63%

MALE >15:1,444,929/29.95% MALE 5-14: 734,284/15.22% MALE 1-5: 322,275/6.68% MALE 0-1: 82,016/1.70%

CHILDREN <1: 160,655/3.33% CHILDREN <2: 291,398/6.04% CHILDREN <5: 806,169/16.71%

2. OVERALL GOAL: To improve the health situation in Central Region

3. PROBLEM STATEMENTS: A. High morbidity and mortality from communicable diseases
B. High maternal morbidity and mortality

4. Description of the immediate objectives with corresponding numbers for problem statements:

A.1 To improve treatment of communicable diseases through use of standard case management
A.2 To obtain reliable health information in order to facilitate planning and evaluation
A.3 To increase access to safe drinking water
A.4 To strengthen existing vector control measures
A.5 To improve environmental sanitation and personal hygiene
A.6 To increase knowledge in general population about better nutrition
B.1 To improve selected MCH structures
B.2 To increase the number of qualified staff
B.3 To increase and maintain regular support for MCH structures

5. Budget Allocation by programming activities:

No.	Programme Activities	Total	Available	Not Available
1	Reproductive Health	5,803,600	5,794,600	9,000
2	EPIs, NIDs, AFP Surveillance, Sub-NIDs	927,964	927,964	0
3	Water & Sanitation	456,300	184,300	272,000
4	Control of communicable diseases	295,000	295,000	0
5	Basic Development Needs (BDN)	0	0	0
6	Improved management (including monitoring systems)	23,500	23,500	0
7	Nutrition	27,500	27,500	0
8	Emergency health	0	0	0
9	Disability	0	0	0
	Grand Total	7,533,864	7,252,864	281,000

6. Budgeting partners and their share (Percentage) in the total available budget:

S.N.	Partner	In amount (US $)	Percentage of available funds
6.1	MOPH	452,000	6%
6.2	UN Agencies	2,376,617	33%
6.3	INGOs (including LNGOs)	4,424,247	61%
6.4	LNGOs		
6.5	Private Donations		
5.6	Communities or user groups		
	Total	7,252,864	100%

	Not committed	281,000	4%

SUMMARY OF THE ACTION PLAN OF EASTERN REGION FOR 1998

1. REGION: Eastern

1.1 No. of provinces in region: 3: Nangarhar, Laghman, Kunar

1.2 No. of districts in region: 41: Nangarhar 21, Laghman 6, Kunar 14

1.3 No. of villages in region: 1,182: Nangarhar 494, Laghman 332, Kunar 356

1.4 Total population: 1,963,405: Nangarhar 1,120,751, Laghman 466,864, Kunar 375,790

1.5 Population of each of the following categories and their respective percentage in total population:

CBAF 15-45: 366,764/18.68% FEMALE 5-14: 266,236/13.56% FEMALE 1-5: 131,548/6.70%
FEMALE 0-1:32,004/1.63%

MALE >15: 588,040/29.95% MALE 5-14: 298,830/15.22% MALE 1-5: 131,155/6.68%
MALE 0-1: 33,378/1.70%

CHILDREN <1: 65,381/3.33% CHILDREN <2: 118,590/6.04%
CHILDREN <5: 328,085/16.71%

2. OVERALL GOAL: To improve the overall health status of the Eastern Region's population

3. PROBLEM STATEMENTS:
   A. High maternal and child mortality and morbidity
   B. High incidence of communicable diseases
   C. Poor health management

4. Description of the immediate objectives with corresponding numbers for problem statements:

A.1 To reduce maternal and child morbidity by 10 % in 1998
B.1 To reduce ARI and CDD morbidities by 5 %, Malaria incidence by 10 % and TB by 2 %
B.2 To improve water and sanitation facilities and access in the region
B.3 To conduct effective community awareness and health education
B.4 Proper planning and proper emergency management

5. Budget Allocation by programming activities:

No.	Programme Activities	Total	Available	Not Available
1	Reproductive Health	63,608	63,608	0
2	EPIs, NIDs, AFP Surveillance, Sub-NIDs	561,531	561,531	0
3	Water & Sanitation	722,799	722,799	0
4	Control of communicable diseases	431,500	421,500	10,000
5	Basic Development Needs (BDN)	26,600	26,600	0
6	Improved management (including monitoring systems)	545,996	545,996	0
7	Nutrition	0	0	0
8	Emergency health	0	0	0
9	Disability	0	0	0
	Grand Total	2,352,034	2,342,034	10,000

6. Budgeting partners and their share (Percentage) in the total available budget:

S.N.	Partner	In amount (US $)	Percentage of available funds
6.1	MOPH	351,305	15%
6.2	UN Agencies	1,053,915	45%
6.3	INGOs (including LNGOs)	632,349	27%
6.4	LNGOs	234,203	10%
6.5	Private Donations	-	-
5.6	Communities or user groups	70,261	3%
	Total	2,342,034	100%

Not committed	10,000	0.4%

SUMMARY OF THE ACTION PLAN OF SOUTHERN REGION FOR 1998

1. REGION: Southern

1.1 NO. OF PROVINCES IN REGION: 5: Nimroze, Kandahar, Uruzgan, Zabul, Helmand

1.2 NO. OF DISTRICTS IN REGION: 52: Nimroze 5, Kandahar 16, Uruzgan 9, Zabul 9, Helmand 13

1.3 NO. OF VILLAGES IN REGION: 3362: Nimroze 458, Kandahar 835, Uruzgan 401, Zabul 830, Helmand 838

1.4 TOTAL POPULATION: 2,722,324: Nimroze 155,698 Kandahar 863,796 Uruzgan 655,663 Zabul 269,469 Helmand 777,698

1.5 Population of each of the following categories and their respective percentage in total populaton :

CBAF 15-45: 508,530/18.68% FEMALE 5-14: 369,147/13.56% FEMALE 1-5: 182,396/6.70% FEMALE 0-1:44,374/1.63%

MALE >15: 815,336/29.95% MALE 5-14: 414,338/15.22% MALE 1-5: 181,851/6.68% MALE 0-1: 46,279/1.70%

CHILDREN <1: 90,653/3.33% CHILDREN <2: 164,428/6.04% CHILDREN <5: 454,900/16.71%

2. OVERALL GOAL: To strengthen the health systems, practices and the status of population

3. PROBLEM STATEMENTS:

A. High mortality and morbidity of CBA women
B. High mortality and morbidity of under five children
C. Poor management
D. Low capacity and performance of provincial hospitals
E. Dire need of physical and functional rehabilitation of BHCs
F. High incidence of disability

4. Description of the immediate objectives with corresponding numbers for problem statements:

A.1 To reduce maternal mortality to 1,500/100,000 live births through promotion of safe motherhood initiative and through control of communicable diseases

B.1 To reduce under five children mortality to 210/1,000 live births through control of communicable diseases

C.1 To improve the health management system and practices

D+E.1 To enhance the capacity of health providers (females and males)

D+E.2 To rehabilitate and improve existing health facilities in 15 districts of 5 provinces

F.1 To reduce the incidence of disability through increased orthopedic, orthotic and physiotherapy and improved referral systems

5. Budget Allocation by programming activities:

No.	Programme Activities	Total	Available	Not Available
1	Reproductive Health	50,000	50,000	0
2	EPIs, NIDs, AFP Surveillance, Sub-NIDs	513,577	513,577	0
3	Water & Sanitation	105,109	105,109	0
4	Control of communicable diseases	99,896	96,026	3,870
5	Basic Development Needs (BDN)	0	0	0
6	Improved management (including monitoring systems)	502,616	425,616	77,000
7	Nutrition	13,010	13,010	0
8	Emergency health	0	0	0
9	Disability	303,439	303,439	0
	Grand Total	1,587,647	1,506,777	80,870

6. Budgeting partners and their share (Percentage) in the total available budget:

S.N.	Partner	In amount (US $)	Percentage of available funds
6.1	MOPH	226,017	15%
6.2	UN Agencies	828,727	55%
6.3	INGOs (including LNGOs)	452,033	30%
6.4	LNGOs		
6.5	Private Donations		
5.6	Communities or user groups		
	Total	1,506,777	100%

	Not committed	80,870	5%

NOTE:

i) Contributions from ICRC, MSF and DACAAR are not included as they were not present
ii) Mid-term review workshop at regional level will be held in July, 1998
iii) Zabul, Nimroze and Uruzgan are the priority provinces for 1998 planned interventions

SUMMARY OF THE ACTION PLAN OF WESTERN REGION FOR 1998

1. REGION: Western

1.1 NO. OF PROVINCES IN REGION: 4: Heart, Farah, Badghis, Ghor

1.2 NO. OF DISTRICTS IN REGION: 37: Herat 13, Farah 11, Badghis 6, Ghor 7

1.3 NO. OF VILLAGES IN REGION: 2857: Herat 1102, Farah 552, Badghis 336, Ghor 867

1.4 TOTAL POPULATION: 2,366,754: Herat 1,016,238 Farah 491,735 Badghis 350,975 Ghor 507,807

1.5 Population of each of the following categories and their respective percentage in total population:

CBAF 15-45: 442,110/18.68% FEMALE 5-14: 320,932/13.56% FEMALE 1-5: 158,573/6.70%
FEMALE 0-1:38,578/1.63%

MALE >15: 708,843/29.95% MALE 5-14: 360,220/15.22% MALE 1-5: 158,099/6.68%
MALE 0-1: 40,235/1.70%

CHILDREN <1: 78,813/3.33% CHILDREN <2: 142,952/6.04%
CHILDREN <5: 395,485/16.71%

2. OVERALL GOAL: To improve the health status of population in Western Region

3. PROBLEM STATEMENTS:

A. High mortality rate among under five children
B. High maternal mortality rate
C. High mortality and morbidity rates due to communicable diseases
D. Poor management skills and knowledge at all levels of heath facilities

4. Description of the immediate objectives with corresponding numbers for problem statements:

A.1 To reduce maternal mortality rate to 1300/100000 live births
B.1 To reduce child mortality rate to 200/1000 live births
C.1 To reduce the prevalence of TB from 2.5% to 2%
C.2 To reduce the incidence of ARI from 17% to 13%
C.3 To reduce the incidence of CDD from 14% to 10%
C.4 To reduce the incidence of Malaria from 3.3% to 2%
C.5 To reduce the incidence Leishmania from 0.6% to 0.3%
C.6 To reduce the incidence of eye infections from 1.5% to 0.1%
D.1 To establish and strengthen one RHMG and two PHMG in Farah and Badghis
D.2 To strengthen the management capacity/efficiency through increased number of coordination meetings
D.3 To establish a strong HIS department for the region

5. Budget Allocation by programming activities:

No.	Programme Activities	Total	Available	Not Available
1	Reproductive Health	868,203	784,703	83,500
2	EPIs, NIDs, AFP Surveillance, Sub-NIDs	400,000	400,000	0
3	Water & Sanitation	1,504,600	979,100	525,500
4	Control of communicable diseases	1,167,203	924,703	242,500
5	Basic Development Needs (BDN)	69,500	69,500	0
6	Improved management (including monitoring systems)	1,031,190	519,190	512,000
7	Nutrition	79,700	79,700	0
8	Emergency health	900	900	0
9	Disability	0	0	0
	Grand Total	5,121,296	3,757,796	1,363,500

6. Budgeting partners and their share (percentage) in the total available budget:

S.N.	Partner	In amount (US $)	Percentage Of available funds
6.1	MOPH	187,890	5%
6.2	UN Agencies	1,615,852	43%
6.3	INGOs (including LNGOs)	1,991,632	53%
6.4	LNGOs		
6.5	Private Donations		
5.6	Communities or user groups		
	Total	3,757,796	100%

	Not committed	1,363,500	27%

NOTE: Since most of the stakeholders from the region were not participating in the workshop the detailed budget was not included in presentation

SUMMARY OF THE ACTION PLAN OF SOUTH-EASTERN REGION FOR 1998

1. REGION: South Eastern

1.1 NO. OF PROVINCES IN REGION: 4: Ghazni, Paktia, Paktika, Khost

1.2 NO. OF DISTRICTS IN REGION: 60: Ghazni 16, Paktia 15, Paktika 18, Khost 11

1.3 NO. OF VILLAGES IN REGION: 3392: Ghazni 1508, Paktia 1236, Paktika 648, Khost (? will come from Paktia's figure)

1.4 TOTAL POPULATION: 2,041,152: Ghazni 947,226 Paktia 422,540 Paktika 367,673 Khost 303,713

1.5 population of each of the following categories and their respective percentage in total population:

CBAF 15-45: 381,287/18.68% FEMALE 5-14: 278,780/13.56% FEMALE 1-5: 136,757/6.70%
FEMALE 0-1:33,271/1.63%

MALE >15: 611,325/29.95% MALE 5-14: 310,663/15.22% MALE 1-5: 136,349/6.68%
MALE 0-1: 34,700/1.70%

CHILDREN <1: 67,970/3.33% CHILDREN <2: 123,286/6.04%
CHILDREN <5: 341,076/16.71%

2. OVERALL GOAL: To reduce mortality and morbidity rates, especially among women of CBA and under five children

3. PROBLEM STATEMENTS:
A. High incidence of communicable diseases
B. High maternal mortality
C. High child mortality

4. description of the immediate objectives with corresponding numbers for problem statements:

A. To reduce the incidence of communicable diseases by 10% by the end of 1998
B. To reduce the maternal mortality by 20% of the present rate by end of 1998
C. To reduce under five children mortality by 20% of the present rate by end of 1998

5. Budget Allocation by programming activities:

No.	Programme Activities	Total	Available	Not Available
1	Reproductive Health	194,800	100,200	94,600
2	EPIs, NIDs, AFP Surveillance, Sub-NIDs	589,253	589,253	0
3	Water & Sanitation	87,500	37,000	50,500
4	Control of communicable diseases	369,750	302,550	67,250
5	Basic Development Needs (BDN)	29,500	29,500	0
6	Improved management (including monitoring systems)	299,324	48,264	251,010
7	Nutrition	40,600	30,200	10,400
8	Emergency health	0	0	0
9	Disability	0	0	0
	Grand Total	1,610,727	1,136,967	473,760

6. Budgeting partners and their share (percentage) in the total available budget:

S.N.	Partner	In amount (US $)	Percentage of available funds
6.1	MOPH	11,370	1%
6.2	UN Agencies	488,896	43%
6.3	INGOs (including LNGOs)	534,374	47%
6.4	LNGOs	102,327	9%
6.5	Private Donations		
5.6	Communities or user groups		
	Total	1,136,967	100%

	Not committed	473,760	29%

NOTE: Work plans, including budgets of ICRC, MSF, ARCS, Federation of Red Cross and Shuhada are not included in it.

EXECUTIVE SUMMARY

The primary objective of the Health Sector Planning Workshop[2] was to provide an opportunity to all the stakeholders of the health sector (local authorities including MOPH, UN agencies, field-based donors, local NGOs, international NGOs) to take a realistic stock of their institutional and operational context at micro and macro levels; to deliberate and reflect on the success and lessons drawn from 1997 work plan process; to agree on a common and achievable set of health priorities for Afghanistan for 1998 fiscal year; and, lastly, make decisions regarding the allocation of collectively available resources (human, financial, institutional) based on the principles of equity and social justice.[3]

It is the first time in the history of health sector in Afghanistan that **all** stakeholders, together, reflected on the health problems of their respective regions. The problem trees thus developed and the resultant prioritisation identified high mortality and morbidity rate among mothers and the under five children as the two most serious problems. Therefore, the regional work-plans focus on the reduction measures for these two key priorities for 1998, the former through effective reproductive health interventions and control of communicable diseases, and the later through effective EPI programmes as well as control of diarrhoeal diseases (DD) and acute respiratory infections (ARI). Another problem identified as a key priority for 1998 is the lack of effective and efficient management system, structure and practices.

The planned tangible output of the workshop are two. First, based on the collectively agreed and owned priorities, detailed work-plans for each of the participating region were prepared by all the participating stakeholders.[4] And, second, as detailed a health profile as possible for each of the region and province represented in the workshop was developed as part of a WHO initiated exercise to set-up a Health Information and Management System (HIMS) and a database at regional and provincial levels.[5] The critical importance of such a system in health sector planning, management, monitoring and impact assessment has been, since long, established in the countries where WHO has been engaged in its promotive, advisory, advocacy and supportive capacity. The aim, as well as the collective challenge for us all, is to ensure that this exercise maintains at least the minimum standards set for HIMS by WHO.

However, equally, if not more important, there have been other, intangible, outputs of this workshop. These are more in the form of the processes, rather than the planned products, which WHO has initiated with the faith and confidence that others will take equal responsibility in ensuring the continuous nurturing of these processes. This includes, primarily much needed trust-building process to strengthen the partnerships amongst the health sector stakeholders of Afghanistan. The second,

2. The pre-planning workshops, were held between late January and early February, 1998, in 22 provinces of six regions. However, due to the security and extreme weather conditions, only five regions representing 20 provinces could participate in the Health Sector Planning Workshop held in Kabul. The output of the pre-planning workshops, especially suggested priorities, were brought in the planning workshop by the regional teams which were used as the basis to develop priorities for 1998.

3. We are happy to note that the methodology, the process and the essential components later defined for the concept of "Common Programming", as the key feature of the "Assistance Strategy for Afghanistan", were the same as the ones employed by WHO in the workshop aiming at common programming for the health sector. As the logical next step we expect that in the Health Sector Planning Workshop for 1999 we will be able to ensure more broad-based and cross-sectoral participation.

4. A summarised version of the five regional workplans is presented in ANNEX I to V. The summary includes total, available and not available budget allocated against programming activities as well financial commitments made by different stakeholders in the available budget and lastly, the estimates of money, which need to be appealed for.

5. Findings (section 5) presents some comparative health data extracted from the detailed profiles of provinces and regions. A brief summary of health profiles for each of the five regions are attached in ANNEXES VI to X. Copies of detailed regional and provincial profiles can be obtained from any of the sub-offices or the support office of WHO Afghanistan.

Central Region (Kabul, Logar, Wardak, Kapisa, Parwan & Bamyan)
Number and type of facilities in the region by provider and package of service they provide

Type of facility	No.	Supporting agency	Bed capacity for				Package of services provided
			Male	Female	Children	Total	
National/Regional hospital	14	MOPH,UN AGENCIES AND NGOS	1557	715	551	2823	Tertiary care + Training
Provincial hospital	9	MOPH,UN AGENCIES AND NGOS				170	Tertiary care + Training
District hospital	12	MOPH,UN AGENCIES AND NGOS				150	Secondary care + Immunization + Health Education & Training
Other hospitals							
Policlinic/clinic	2	MOPH,UN AGENCIES AND NGOS					Ambulatory care + Immunization
Comprehensive/Basic health center	68	MOPH,UN AGENCIES AND NGOS					Ambulatory care, Immunization, H.E., Antenatal care + Minor surgery
Sub-health center	47	MOPH,UN AGENCIES AND NGOS					Ambulatory care, Immunization, H.E., Antenatal care + Minor surgery
MCH centers	49	MOPH,UN AGENCIES AND NGOS					Ambulatory care + Minor surgery + Immunization , H.E. Antenatal care, TBA training
Health post	82	MOPH AND NGOS					Ambulatory care + H.E. and First Aid.
EPI Fix center							Immunization
Other							
ARCS							
TOTAL			1,557	715	551	3,143	

- Total number of pharmacies in the region: **1,714**

- Number of beds for every 10,000 population

Male	Female	Children	Total
10.8	6.0	2.5	6.5

Central Region (Kabul, Logar, Wardak, Kapisa, Parwan & Bamyan)
Total number and type of health personnel broken down by gender and its proportion for every 10,000 population

Type of Health personnel	Govt. supported facilities		NGOs supported Health facilities		Total		Grand Total	No. of H. Staff /10,000 Population		
	Male	Female	Male	Female	Male	Female		Male	Female	Total
- Medical Doctor	590	410	22	3	612	413	1,025	1.3	0.9	2.1
- Anesthetist/Ass. Anesthetist	42	1	0	0	41	1	42	0.1	0.0	0.1
- Dentist	29	8	6		29	14	43	0.1	0.0	0.1
- Assistant Dentist	54	17		1	54	18	72	0.1	0.0	0.1
- Nurses	687	635	26	8	713	643	1,356	1.5	1.3	2.8
- Midwives		350		3		353	353	-	0.7	0.7
- Pharmacist	137	45	5		142	45	187	0.3	0.1	0.4
- Assistant Pharmacists	50	17	1		51	17	68	0.1	0.0	0.1
- Lab. Technician	303	45	11		314	45	359	0.7	0.1	0.7
- Field Microscopist	42				42		42	0.1	-	0.1
- X-Ray Technician	124	10			124	10	134	0.3	0.0	0.3
- Vaccinator	60	53	21	3	81	56	137	0.2	0.1	0.3
- Sanitarian	82				82		82	0.2	-	0.2
- Mid-level Health Worker	192		11		203		203	0.4	-	0.4
- Basic Health Workers	2		34		36		36	0.1	-	0.1
_ TBA		330		22		352	352	-	0.7	0.7
_ Village health volunteer (VHV)	2,144			4	2,144	4	2,148	4.4	0.0	4.5

Eastern Region (Nangarhar, Kunar, & Laghman)
Number and type of facilities in the region by provider and package of service they provide

Type of facility	No.	Supporting agency	Bed capacity for				Package of services provided
			Male	Female	Children	Total	
Regional hospital	2	MoPH,ICRC,HF,WHO,UNICEF,WFP	375	135	50	560	Tertiary care + Training
Provincial hospital	2	MoPH,AMI,PSF,WHO,UNICEF,WFP	40	20	20	80	Tertiary care + Training
District hospital	2	MoPH,HNI,EREA,WHO,UNICEF,WFP	25	15	20	60	Secondary care + Immunization + Health Education & Training
Other hospitals	5	IIRO,AGHCO,Inter Plast,IIF,AOGH	60	40	50	150	
Policlinic/clinic	1	MoPH,WHO,UNICEF					Ambulatory care + Immunization
Comprehensive/Basic health center	49	MOPH,SCA,HNI,ARC,IIRO,AFRC,AMI, Afghan Jap,Isra,WHO,UNICEF.					Ambulatory care, Immunization, H.E., Antenatal care + Minor surgery
Sub-health center	16	MoPH,SCA,WHO,UNICEF					Ambulatory care, Immunization, H.E., Antenatal care + Minor surgery
MCH centers	9	Ibnisina,KN,HAWAD,UMCA,MoPH,WHO,UN					Ambulatory care + Minor surgery + Immunization , H.E. Antenatal care, TBA training
Health post	9						Ambulatory care + H.E. and First Aid.
EPI Fix center	82	MoPH,UNICEF,HN,IIRO,WHO					Immunization
Other							
TOTAL			500	210	140	850	

- Total number of pharmacies in the region: **503**

- Number of beds for every 10,000 population

Male	Female	Children	Total
8.5	4.4	1.6	4.3

Eastern Region (Nangarhar, Kunar, & Laghman)
Total number and type of health personnel broken down by gender and its proportion for every 10,000 population

Type of Health personnel	Govt. supported facilities		NGOs supported Health facilities		Total		Grand Total	No. /10,000 Population		
	Male	Female	Male	Female	Male	Female		Male	Female	Total
- Medical Doctor					240	62	302	1.2	0.3	1.5
- Anesthetist/Ass. Anesthetist					11	-	11	0.1	-	0.1
- Dentist					4	1	5	0.0	0.0	0.0
- Assistant Dentist					30	1	31	0.2	0.0	0.2
- Nurses					268	34	302	1.4	0.2	1.5
- Midwives						137	137	-	0.7	0.7
- Pharmacist					21		21	0.1	-	0.1
- Assistant Pharmacists							-	-	-	-
- Lab. Technician					47		47	0.2	-	0.2
- Field Microscopist					61		61	0.3	-	0.3
- X-Ray Technician					12		12	0.1	-	0.1
- Vaccinator					146	28	174	0.7	0.1	0.9
- Sanitarian							-	-	-	-
- Mid-level Health Worker							-	-	-	-
- Basic Health Workers							-	-	-	-
_ TBA						1088	1,088	-	5.5	5.5
_ Village health volunteer (VHV)					192		192	1.0	-	1.0

South Eastern Region (Ghazni, Paktika, Paktya, & Khost)
Number and type of facilities in the region by provider and package of service they provide

Type of facility	No.	Supporting agency	Bed capacity for				Package of services provided
			Male	Female	Children	Total	
Regional hospital	1	WHO., ICRC, MSF, INBNESINA	50	34	28	112	Tertiary care + Training
Provincial hospital	3	IIRO, LEGNA	30	20	10	60	Tertiary care + Training
District hospital	4	LEGNA, SHOHADA ORGAN. NAC, IBNSINA	30	30	15	75	Secondary care + Immunization + Health Education & Training
Other hospitals	1	TB- CONTROL (MSF)	10	10		20	
Policlinic/clinic							Ambulatory care + Immunization
Comprehensive/Basic health center	18	SCA, NAC, ARCS					Ambulatory care, Immunization, H.E., Antenatal care + Minor surgery
Sub-health center	36	SCA, MOPH					Ambulatory care, Immunization, H.E., Antenatal care + Minor surgery
MCH centers	17	LEGNA, IBNSINA, IIRO					Ambulatory care + Minor surgery + Immunization , H.E. Antenatal care, TBA training
Health post							Ambulatory care + H.E. and First Aid.
EPI Fix center	61	UNICEF, WHO, NAC, IBNSINA, SCA					Immunization
Other							
ARCS							
TOTAL			120	94	53	267	

- Total number of pharmacies in the region: **522**

-

- **Number of beds for every 10,000 population**

Male	Female	Children	Total
2.0	1.9	0.6	1.3

South Eastern Region (Ghazni, Paktika, Paktya, & Khost)

Total number and type of health personnel broken down by gender and its proportion for every 10,000 population

Type of Health personnel	Govt. supported facilities		NGOs supported Health facilities		Total		Grand Total	No. /10,000 Population		
	Male	Female	Male	Female	Male	Female		Male	Female	Total
- Medical Doctor	9	2	78	25	87	27	114	0.4	0.1	0.6
- Anesthetist/Ass. Anesthetist			10		10		10	0.0	-	0.0
- Dentist			4		4		4	0.0	-	0.0
- Assistant Dentist	1		15		16		16	0.1	-	0.1
- Nurses	6		130	20	136	20	156	0.7	0.1	0.8
- Midwives	3				3		3	0.0	-	0.0
- Pharmacist	7		8		15		15	0.1	-	0.1
- Assistant Pharmacists			13		13		13	0.1	-	0.1
- Lab. Technician	1		36		37		37	0.2	-	0.2
- Field Microscopist	2		2		4		4	0.0	-	0.0
- X-Ray Technician			12		12		12	0.1	-	0.1
- Vaccinator			105	7	105	7	112	0.5	0.0	0.5
- Sanitarian							-	-	-	-
- Mid-level Health Worker			74		74		74	0.4	-	0.4
- Basic Health Workers							-	-	-	-
_ TBA				319		319	319	-	1.6	1.6
_ Village health volunteer (VHV)	31				31		31	0.2	-	0.2

Southern Region (Kandahar, Helmand, Zabul, Oruzgan & Nimroz)
Number and type of facilities in the region by provider and package of service they provide

Type of facility	No.	Supporting agency	Bed capacity for				Package of services provided
			Male	Female	Children	Total	
Regional hospital	1	MOPH (WHO, UNICEF, ICRC)				236	Tertiary care + Training
Provincial hospital	4	MOPH (WHO, UNICEF, MSF, UNHCR)	70	50	25	145	Tertiary care + Training
District hospital	8	MOPH (WHO, UNICEF, AHDS, IBNISINA, MSF	14	10	6	30	Secondary care + Immunization + Health Education & Training
Other hospitals	2	MOPH (AL-KHIDMAT, IAHC)	10	10		20	
Policlinic/clinic	0						Ambulatory care + Immunization
Comprehensive/Basic health center	11	MOPH (AHDS, WHO, UNICEF					Ambulatory care, Immunization, H.E., Antenatal care + Minor surgery
Sub-health center	6	MOPH					Ambulatory care, Immunization, H.E., Antenatal care + Minor surgery
MCH centers	8	MOPH (UNICEF, WHO, MSF, AHDS, IBNISINA)					Ambulatory care + Minor surgery + Immunization , H.E. Antenatal care, TBA training
Health post	14	MOPH, WHO, UNICEF, MSF, IBNESINA					Ambulatory care + H.E. and First Aid.
EPI Fix center	42	MOPH (UNICEF, WHO, IBNESINA)					Immunization
Other							
TOTAL			94	70	31	431	

- Total number of pharmacies in the region: **189**
-

- **Number of beds for every 10,000 population**

Male	Female	Children	Total
1.2	1.0	0.3	1.6

Southern Region (Kandahar, Helmand, Zabul, Oruzgan & Nimroz)
Total number and type of health personnel broken down by gender and its proportion for every 10,000 population

Type of Health personnel	Govt. supported facilities		NGOs supported Health facilities		Total		Grand Total	No. /10,000 Population		
	Male	Female	Male	Female	Male	Female		Male	Female	Total
- Medical Doctor	40	7	41	6	81	13	94	0.3	0.0	0.3
- Anesthetist/Ass. Anesthetist	7	-	1	-	8	-	8	0.0	-	0.0
- Dentist	6	-	-	-	6	-	6	0.0	-	0.0
- Assistant Dentist	22	-	4	-	26	-	26	0.1	-	0.1
- Nurses	148	24	43	13	191	37	228	0.7	0.1	0.8
- Midwives	-	8	-	8	-	16	16	-	0.1	0.1
- Pharmacist	21	2	6	-	27	2	29	0.1	0.0	0.1
- Assistant Pharmacists	4	-	4	-	8	-	8	0.0	-	0.0
- Lab. Technician	22	-	16	-	38	-	38	0.1	-	0.1
- Field Microscopist	9	-	-	-	9	-	9	0.0	-	0.0
- X-Ray Technician	13	-	10	-	23	-	23	0.1	-	0.1
- Vaccinator	79	11	-	-	79	11	90	0.3	0.0	0.3
- Sanitarian	-	-	-	-	-	-	-	-	-	-
- Mid-level Health Worker	18	-	32	-	50	10	60	0.2	0.0	0.2
- Basic Health Workers	24	-	24	-	48	-	48	0.2	-	0.2
_ TBA	-	88	-	238	-	326	326	-	1.2	1.2
_ Village health volunteer (VHV)	50	-	80	-	130	-	130	0.5	-	0.5

Western Region (Herat, Farah, Ghor & Badghis)
Number and type of facilities in the region by provider and package of service they provide

Type of facility	No.	Supporting agency	Bed capacity for				Package of services provided
			Male	Female	Children	Total	
Regional hospital	1	MOPH (WHO, UNICEF, PSF)	150	120	100	370	Tertiary care + Training
Provincial hospital	3	MOPH (WHO, UNICEF, PSF, MDM)	65	35	20	120	Tertiary care + Training
District hospital	2	MOPH (WHO, UNICEF, PSF, CHA, MSF)	10	10	-	20	Secondary care + Immunization + Health Education & Training
Other hospitals	1	MOPH (IAM)	25	15	-	40	
Policlinic/clinic	1	MOPH (WHO, UNICEF, PSF)					Ambulatory care + Immunization
Comprehensive/Basic health center	31	MOPH (WHO, UNICEF, PSF, MERLIN, CHA)					Ambulatory care, Immunization, H.E., Antenatal care + Minor surgery
Sub-health center	10	MOPH (WHO, UNICEF, PSF, MERLIN)					Ambulatory care, Immunization, H.E., Antenatal care + Minor surgery
MCH centers	13	MOPH (WHO, UNICEF, PSF, MDM, CHA)					Ambulatory care + Minor surgery + Immunization , H.E. Antenatal care, TBA training
Health post	259	COMMUNITY, MOPH (WHO, CHA, MERLIN)					Ambulatory care + H.E. and First Aid.
EPI Fix center	56	MOPH (UNICEF, WHO, CHA, MERLIN)					Immunization
Other	6	IDPS- MSF, MDM, CHA, ARCS					
ARCS	6	ARCS, IFRC, ICRC					
TOTAL			250	180	120	550	

- Total number of pharmacies in the region: **212**

- **Number of beds for every 10,000 population**

Male	Female	Children	Total
3.5	3.1	1.1	2.3

ANNEX X (2)

Western Region (Herat, Farah, Ghor & Badghis)

Total number and type of health personnel broken down by gender and its proportion for every 10,000 population

Type of Health personnel	Govt. supported facilities		NGOs supported Health facilities		Total		Grand Total	No. /10,000 Population		
	Male	Female	Male	Female	Male	Female		Male	Female	Total
- Medical Doctor	117	48	11	6	128	54	182	0.5	0.2	0.8
- Anesthetist/Ass. Anesthetist	5	1			5	1	6	0.0	0.0	0.0
- Dentist	18	3			18	3	21	0.1	0.0	0.1
- Assistant Dentist							-	-	-	-
- Nurses	290	38			290	38	328	1.2	0.2	1.4
- Midwives		20		8		28	28	-	0.1	0.1
- Pharmacist	12	10	10	2	20	12	32	0.1	0.1	0.1
- Assistant Pharmacists							-	-	-	-
- Lab. Technician	25	4			25	4	29	0.1	0.0	0.1
- Field Microscopist	23	1			23	1	24	0.1	0.0	0.1
- X-Ray Technician	9				9		9	0.0	-	0.0
- Vaccinator	53	18	26	2	79	10	89	0.3	0.0	0.4
- Sanitarian	6				6		6	0.0	-	0.0
- Mid-level Health Worker	92	15			92	15	107	0.4	0.1	0.5
- Basic Health Workers							-	-	-	-
_ TBA		174				174	174	-	0.7	0.7
_ Village health volunteer (VHV)	238		10		248		248	1.0	-	1.0

equally important and needed process initiated by this workshop, is the capacity and skills building of the health sector in systematic, participatory, and bottom-up approaches of planning and monitoring. WHO endeavours to continue providing its leadership in the health sector to institutionalise these planning and monitoring skills and the related practices. The last output is a set of recommendations on key issues of collective concern to all the stakeholders, mostly related with the policy matters. (See ANNEX XI).

The key features of the health profiles present a very alarming situation. Given the fact that almost all regions and provinces in Afghanistan have more or less same incidence and prevalence picture of major disease problems, with few exceptions such as in the case of malaria and leishmaniasis, it is unacceptable that grave disparities exist in allocation and distribution of available health resources. These disparities include health providers, money, health service delivery system, equipment and other supplies and materials, and above all investment and presence of most of the external stakeholders of the health sector in a few, "near to road" districts. For instance, 46 percent of the total reported health sector available budget for 1998 for the five regions are invested in the four provinces of the central region, mainly in Kabul while its share in the total population of the five regions is 29 percent.[6] The data is less helpful in providing details on the intra-regional disparities. Take the example of central region where 40 percent of the total physicians and 42 percent of the total nurses at present in Afghanistan are placed only in Kabul province (one of the six provinces of the region). Likewise 66% of the physicians and 66% of the nurses are working in four provinces, mainly Kabul, Nangarhar, Herat and Mazar. Such data presents challenge to all of us to take immediate and drastic corrective measures if we have to make a reality of the principles of equity and social justice in our collective pursuit to ensure that all Afghan women, children and men are given equal opportunities to the same quality healthcare.

As the details in section 5 on Findings of the workshop indicate, each region has included in its work plan number of intervention strategies to address the priorities for 1998 i.e. the alarmingly high maternal and under five children mortality and morbidity rate. These include programming areas on reproductive health, control of communicable diseases, control of childhood diseases through EPI and NIDs, nutrition, and water and sanitation. The other priority identified by all five regions is weak management. However, emergency health care continues to be a key and major feature of aid community assistance provided to the health sector in Afghanistan. Each region has also identified total budget required for 1998, as well as the available amount and the shortfall, against each of the above programming areas. Agencies which participated in the workshop agreed to appeal to the interested donors for the budget shortfall in their respective regions and programming areas of their organisational interests. WHO undertook to provide technical guidance and support to develop a proposal to appeal the budget shortfall of the health sector occurring in 1998.

End July and August 1998 is the time built in the regional work-plans for mid-year review exercise. This will be done through participatory workshops carried out at the regional levels and participated by all the regional stakeholders. This will provide us all with the opportunity to make realistic reflection and assessment of the situation with regard to the planned targets for the remaining of the year. WHO plans to use this occasion to further update the data on the health profiles so that the serious questions of disparities in resource allocation and distribution can be addressed. At the same time, we should be able to judge the progress made on the recommendations of the workshop dealing with policy measures which have serious implications for the implementation of the work-plans, especially the ones pertaining de-centralisation/regionalization, standardisation of cost sharing

[6] Population estimates included in the central region do not include Parwan and Kapisa as these two provinces were not accessible due to the ongoing war.

MAIN ISSUES RAISED IN THE WORKSHOP AND RECOMMENDATIONS:

1. Issue:

- Streamlining and rationalisation of the assistance to the health sector in order to avoid duplication and wastage of resource.

Recommendations:

- All stakeholders (national and international) including the MOPH should communicate clearly their policies, strategies, and modus operandi without ambiguities so that the national authorities and the international aid community are aware of them.

- MOPH to develop policy on coordination of the inputs to the health sector in consultation with WHO, UNICEF, and NGOs.

- MOPH shall establish and /or strengthen the existing regional and national coordination system.

- MOPH shall fully operationlize the decentralised management of the health care system in Afghanistan and also strengthen the existing RHMT & PHMT to make them an effective level of MOPH management structure.

- The international community (Donors, United Nations, and NGOs) shall support the decentralised health care management system and will assist MOPH in its efforts to rehabilitate the various levels of the health care system and structure in Afghanistan.

- MOPH members shall periodically participate in the Technical Coordination Committee (TCC) meeting held in Peshawar on different issues. This will foster the link between international agencies, donors and MOPH especially to develop together realistic implementation strategies.

- All international and national health agencies will be required to enter a formal agreement with the MOPH by signing a protocol of agreement and a work-plan based on priorities jointly identified by the MOPH and the aid community.

- MOPH will develop policies on technical programmes including long term as well as short term training and communicate the same to all stakeholders before the regional mid-term reviews are held in late July 1998.

- MOPH shall facilitate the work of the aid community within the agreed policy framework, while fully respecting the local regulations

- The international aid community shall endeavour to strengthen the technical and managerial capacity of the national and regional health management teams to ensure that technical and material assistance reaches to the intended beneficiaries.

2. Issue:

- Equity to health care resources

Recommendations:

- MOPH and the aid community shall endeavour to ensure equitable distribution of health care resources, particularly to the provinces and districts that are under served or UN-served.

- MOPH shall develop and operationalize rationalisation of the redistribution of health workers currently concentrated in the capital and main regional centres to the under-served provinces and districts.

- MOPH shall communicate the recent policy of MOPH fully supported and endorsed by the Shura decision on equity, to ensure equal access to health care by all Afghans.

3. Issue

- Standardisation of cost sharing mechanism

Recommendations:

- MOPH to develop a policy on cost sharing and cost recovery systems and shall communicate it to the regional, provincial and district health authorities and to the members of the aid community.

- MOPH will periodically review the progress of the implementation of the cost sharing and cost recovery policy and shall provide directives as required.
- Resources generated through cost recovery (users fee) shall be used for the improvement of the health services, including incentives of the staff of the facility that generated the revenue.

4. Issue

- Standardisation of the incentives provided by the aid community.

Recommendations:

- All international health care providers are encouraged to standardise the incentive package they are giving to the MOPH staff.

- All international agencies shall be required to inform the ministry of public health, well in advance of any changes, regarding the continuation and discontinuation of the assistance package.

- The ministry of public health in consultation with the concerned agency and organization will develop a phased exit strategy.

- MOPH shall organise a consultation workshop by mid-June to develop the exit strategy with the participation of international stakeholders.

5. Issue

- Standardisation of the health information system.

Recommendations:

- MOPH shall issue a policy guideline for introducing a unified health information system.
- WHO, UNICEF and NGOs will provide a written comment on the health information reporting format distributed during the workshop.

6. Issue

- Lack of funds for priorities set by the health sector planning workshop

Recommendations:

- All participants of this workshop (MOPH, INGOs, LNGOs, UN Agencies) undertake the responsibility to appeal for programmes prioritised by them for which funds are not currently available
- Project proposals for the stakeholders will develop these identified priorities interested in these areas of activities and make the appeal by mid April.

7. Issue

Monitoring, evaluation and impact assessment

Recommendations:

- A mid term review, as already designed and incorporated in the regional work plans, will be carried out from mid July to mid August, 1998.

Country Health Profile: Distribution of Health Facilities by Type and by Province in Afghanist

ANNEX XII (1)

No	Name of the province	Population	Health Facility: Regional Hospitals	Provincial Hospitals	District Hospital	Basic Health Center	SUB-Health Center	Health Post	* ARCS Clinic	Poly Clinic	EPI Fixed Center	Labor-atories	MCH Clinic/ Services	TB Control Program	Bed Capacity: Number	Bed Capacity: /10,000 People
1	Nangarhar	1,120,750	2	5	2	34	0	9	1	1	44	0	8	1	770	6.9
2	Laghman	466,864	0	1	0	3	11	0	0	0	16	0	1	0	40	0.9
3	Kunar	375,791	0	1	0	12	5	0	0	0	22	0	0	1	40	1.1
	East Total	1,963,405	2	7	2	49	16	9	1	1	82	0	9	2	850	4.3
1	Kabul	2,519,945	14	4	3	6	5	81	0	2	58	0	45	3	2,813	11.2
2	Wardak	441,428	0	1	4	14	10	0	0	0	12	0	2	0	130	2.9
3	Logar	324,966	0	0	1	6	7	1	0	0	0	0	1	0	50	1.5
4	Parwan	615,236	0	1	0	7	13	0	0	0		0	1	0	150	2.4
5	Kapisa	519,483	0	2	0	11	12	0	0	0		0	0	0		0.0
6	Bamyan	403,412	0	1	4	24	0	0	0	0		0	0	0		0.0
	Center Total	4,824,470	14	9	12	68	47	82	0	2	70	0	49	3	3,143	6.5
1	Ghazni	947,226	1	1	3	11	13	0	0	0	0	0	14	20	182	1.9
2	Paktia	726,254	0	2	1	5	16	0	0	0	9	0	2	0	55	0.8
3	Paktika	367,672	0	1	0	2	7	0	0	0	0	0	1	0	30	0.8
	South East Total	2,041,152	1	4	4	18	36	0	0	0	9	0	17	20	267	1.3
1	Kandahar	863,796	1	2	2	7	0	2	0	0	21	0	4	0	276	3.2
2	Nimroz	155,698	0	1	0	0	1	0	0	0	0	0	0	0	15	1.0
3	Zabul	269,469	0	1	3	0	3	0	0	0	5	0	0	0	20	0.7
4	Helmand	777,698	0	1	1	4	0	0	0	0	11	0	2	0	80	1.0
5	Oruzgan	655,663	0	1	2	0	2	12	0	0	5	0	2	0	40	0.6
	South Total	2,722,324	1	6	8	11	6	14	0	0	42	0	8	0	431	1.6
1	Herat	1,016,238	1	0	1	13	6	165	4	1	33	15	10	5	410	4.0
2	Farah	491,735	0	1	1	11	0	34	1	0	15	7	2	2	70	1.4
3	Badghis	350,975	0	1	1	2	4	60	2	0	3	2	1	1	40	1.1
4	Ghore	507,807	0	1	0	5	0	0	1	0	5	0	0	0	30	0.6
	West Total	2,366,755	1	3	3	31	10	259	8	1	56	24	13	8	550	2.3
1	Balkh	855,235	1	0	5	10	6	0	0	0	-	-	4	-	260	3.0
2	Samangan	409,524	0	1	1	2	1	2	0	0	-	-	0	-	70	1.7
3	Jawzjan	884,309	0	2	14	6	6	12	7	0	-	-	6	-	130	1.5
4	Faryab	876,659	0	1	1	4	6	1	11	1	-	-	1	-	150	1.7
	North Total	3,025,727	1	4	21	22	19	15	18	1	0	0	11	0	610	2.0
1	Badakhshan	747,316	0	1	0	19	0	0	1	1	8	8	4	3	80	1.1
2	Takhar	783,860	0	1	2	7	8	0	1	1	4	0	2	0	50	0.6
3	Baghlan	742,010	0	2	0	10	0	0	0	2	0	0	0	0	165	2.2
4	Kunduz	834,476	0	1	1	0	10	0	0	2	0	0	0	0	100	1.2
	North East Total	3,107,662	0	5	3	36	18	0	2	6	12	8	6	3	395	1.3
	Grand Total	**20,051,495**	**20**	**38**	**53**	**235**	**152**	**379**	**29**	**11**	**271**	**32**	**113**	**36**	**6,246**	**3**

*** ARCS (AFGHAN RED CRESCENT SOCIETY).**

Except for the North and North Eastern regions, the data has been updated during H.S.P.W, Kabul, Feb. 1998

Country Health Profile: Distribution of Health Workers by Category and by Province in Afghanista

ANNEX XII (2)

No	Name of the province	Health Personnel																					
		Physician		Nurse		Pharmacist		Dentist		Lab. Tech		Malaria Microscopist		X-Ray Tech		Midwife		Vaccinator		VHV		TBA	
		No.	/10,000 People	No.	/10,000 People	No.	/10,000 People	No.	/10,000 People	No.	/10,000 People	No.	/10,000 People	No.	/10,000 People	No.	/10,000 People	No.	/10,000 People	No.	/2,000 People	No.	/1,000 People
1	Nangarhar	247	2.2	233	2.1	18	0.2	35	0.3	35	0.3	48	0.4	10	0.1	132	1.2	96	0.9	160	0.3	678	0.6
2	Laghman	40	0.9	50	1.1	2	0.0	1	0.0	1	0.0	13	0.3	1	0.0	3	0.1	32	0.7	0	0.0	360	0.8
3	Kunar	15	0.4	19	0.4	1	0.0	0	0.0	11	0.2	0	0.0	1	0.0	2	0.0	46	1.0	32	0.1	50	0.1
	East Total	302	1.5	302	1.5	21	0.1	36	0.2	47	0.2	61	0.3	12	0.1	137	0.7	174	0.9	192	0.2	1,088	0.6
1	Kabul	892	3.5	1,255	5.0	171	0.7	33	0.1	340	1.3	42	0.2	127	0.5	332	1.3	98	0.4	2,144	1.7	364	0.1
2	Wardak	20	0.5	30	0.7	6	0.1	7	0.2	12	0.3	0	0.0	2	0.0	4	0.1	18	0.4	0	0.0	2	0.0
3	Logar	8	0.2	17	0.5	0	0.0	0	0.0	3	0.1	0	0.0	2	0.1	4	0.1	21	0.6	4	0.0	22	0.1
4	Parwan	58	0.9	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0		0.0		0.0
5	Kapisa	20	0.4	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0		0.0		0.0
6	Bamyan	27	0.7	54	1.3	10	0.2	3	0.1	4	0.1	0	0.0	3	0.1	13	0.3	0	0.0		0.0		0.0
	Center Total	1,025	2.1	1,356	2.8	187	0.4	43	0.1	359	0.7	42	0.1	134	0.3	353	0.7	137	0.3	2,148	0.9	388	0.1
1	Ghazni	84	0.9	120	1.3	8	0.1	3	0.0	26	0.3	2	0.0	7	0.1	0	0.0	53	0.6	0	0.0	264	0.3
2	Paktia	18	0.2	19	0.3	6	0.1	1	0.0	6	0.1	0	0.0	3	0.0	3	0.0	36	0.5	31	0.1	55	0.1
3	Paktika	12	0.3	17	0.5	1	0.0	0	0.0	5	0.1	2	0.1	2	0.1	0	0.0	18	0.5	0	0.0	0	0.0
	South East Total	114	0.6	156	0.8	15	0.1	4	0.0	37	0.2	4	0.0	12	0.1	3	0.0	107	0.5	31	0.0	319	0.2
1	Kandahar	55	0.6	179	2.1	21	0.2	2	0.0	28	0.3	0	0.0	12	0.1	7	0.1	42	0.5	0	0.0	46	0.1
2	Nimroz	5	0.3	5	0.3	1	0.1	2	0.1	2	0.1	0	0.0	1	0.1	2	0.1	8	0.5	0	0.0	12	0.1
3	Zabul	5	0.2	11	0.4	4	0.1	2	0.1	3	0.1	3	0.1	7	0.3	2	0.1	10	0.4	50	0.4	0	0.0
4	Helmand	25	0.3	31	0.4	3	0.0	0	0.0	5	0.1	6	0.1	2	0.0	2	0.0	20	0.3	0	0.0	30	0.0
5	Oruzgan	4	0.1	2	0.0	0	0.0	0	0.0	0	0.0	0	0.0	1	0.0	3	0.0	10	0.2	80	0.2	238	0.4
	South Total	94	0.3	228	0.8	29	0.1	6	0.0	38	0.1	9	0.0	23	0.1	16	0.1	90	0.3	130	0.1	326	0.1
1	Herat	146	1.4	209	2.1	23	0.2	18	0.2	22	0.2	13	0.1	6	0.1	18	0.2	52	0.5	164	0.3	134	0.1
2	Farah	24	0.5	85	1.7	5	0.1	2	0.0	6	0.1	10	0.2	2	0.0	5	0.1	27	0.5	24	0.1	30	0.1
3	Badghis	8	0.2	22	0.6	3	0.1	0	0.0	1	0.0	1	0.0	1	0.0	4	0.1	5	0.1	60	0.3	10	0.0
4	Ghore	4	0.1	12	0.2	3	0.1	1	0.0	0	0.0	0	0.0	0	0.0	1	0.0	5	0.1	0	0.0	0	0.0
	West Total	182	0.8	328	1.4	34	0.1	21	0.1	29	0.1	24	0.1	9	0.0	28	0.1	89	0.4	248	0.2	174	0.1
1	Balkh	181	2.1	276	3.2	10	0.1	14	0.2	8	0.1		0.0	12	0.1	80	0.9	68	0.8	51	0.1	160	0.2
2	Samangan	10	0.2	12	0.3	4	0.1	1	0.0	1	0.0		0.0	1	0.0	0	0.0	12	0.3	0	0.0	10	0.0
3	Jawzjan	137	1.5	107	1.2	12	0.1	5	0.1	8	0.1		0.0	6	0.1	23	0.3	39	0.4	40	0.1	75	0.1
4	Faryab	51	0.6	34	0.4	11	0.1	2	0.0	4	0.0		0.0	1	0.0	4	0.0	18	0.2	40	0.1	20	0.0
	North Total	379	1.3	429	1.4	37	0.1	22	0.1	21	0.1	0	0.0	20	0.1	107	0.4	137	0.5	131	0.1	265	0.1
1	Badakhshan	38	0.5	43	0.6	8	0.1	3	0.0	14	0.2		0.0	1	0.0	10	0.1	21	0.3	174	0.5	150	0.2
2	Takhar	40	0.5	65	0.8	4	0.1	0	0.0	16	0.2		0.0	5	0.1	0	0.0	0	0.0	0	0.0	0	0.0
3	Baghlan		0.0		0.0		0.0		0.0		0.0		0.0		0.0		0.0		0.0		0.0		0.0
4	Kunduz	54	0.6	69	0.8	0	0.0	0	0.0	11	0.1		0.0	2	0.0	0	0.0	0	0.0	0	0.0	0	0.0
	North East Total	132	0.4	177	0.6	12	0.0	3	0.0	41	0.1	0	0.0	8	0.0	10	0.0	21	0.1	174	0.1	150	0.0
	Grand Total	2,228	1.1	2,976	1.5	335	0.2	135	0.1	572	0.3	140	0.1	218	0.1	654	0.3	755	0.4	3,054	0.3	2,710	0.1

Except for the North and North Eastern regions, the data has been updated during H.S.P.W, Kabul, Feb. 1998

Sharing Information Recommendation and Achievement of MOPH Health Sector Planning Workshop 15 Feb/1998 to 21 Feb/1998

I: Support from high ranking government Authority:

1- *His Excellency Mawlawi Kabir Vice president of The Council in Charge of the Islamic Emirate of Afghanistan.*

- *The Islamic Emirate, by all means is ready to solve all their professional problems and endeavors to provide them with all the necessary facilities and try to put in the disposal of Health personal all his present possibilities.*

- *On behalf of His Excellency Amirulmominin Mulla Mohammad Omar Mojahed and the Council in Charge of the Islamic Emirate, I promise you all sorts of supports and helps so that medicine may expand more in our society and the level of medical care and prevention of diseases may be raised more and more.*

2- *Their Excellencies Members of cabinet . . .*

3- *His excellency Minister of Public Health.*

- *Improving of Health in deprived areas is priority for MOPH.*

II-Management and service delivery:

1- *All the public health directorate (22 Province) had the chance to come together, and had the opportunity to discuss their organizational, financial, logistic and man power problems, and obstacles toward the Achievement of PHC goal.*

2- *The importance of Health information system was clarified, that always reporting should be from peripheral to the center and a feedback from the top to bottom.*

3- *The elements of PHC were discussed, the strategy of PHC was agreed upon. It was agreed that external supports should be directed towards PHC implementation, particularly in the area where no health facilities are available.*

4- *Multisec toral Co-operation in rural area is important factor in the implementation of PHC and rural development. Rural development Dept. should be supported in other fields of rural development not only on the health.*

5- *The integration of MCH in PHC implementation was discussed and it was agreed that SMI (Safe Motherhood Initiatives) strategy must be implemented at rural areas to provide EOC (Emergency Obstetric Care). The major obstacle in the implementation of this strategy was considered the lack of health professional staff in health facilities.*

6- *Environmental health was discussed, it was agreed that one of the most important item is control of communicable disease (Diarrhoeal Disease, ARI). It was agreed that for the control of gastro-intestinal diseases the provision of safe drinking water and sanitation are the most important points.*

7- *The prevalence of TB, Malaria, and leishmaniasis was discussed, it was considered as an almost universal problems in Afghanistan and New approaches of prevention and treatment was agreed upon.*

8- *The various drugs imported to the country by different organization has created a problem in the use of drug by the various health personnel. It was suggested that the production and importation of drug in Afghanistan should be according to National formulary of Afghanistan, and at the end their use should be rational, and quality control Lab. should be rehabilitated.*

9- *All the Public Health Directorate and doctors realized the importance of Health Education in implementation of PHC programs, and Promised to promote Health Education in their provinces.*

10-*In the continuation of PHC/Environmental health programs community participation and social mobilization was considered as an important items and The Public Health Directors promised to involve the community in different stages of the programs implementation.*

OVERVIEW OF THE IMPLEMENTATION OF PHC & EMERGENCY PROGRAM IN 1997

The Ministry of Public Health in Afghanistan has accepted the strategy of PHC for the goal of Health for all for along time. In the implementation of its elements we have been successful in some of the areas, where financial resources were available. For example:
***EPI** which was existed for many years but limited to large cities and centralized, with the availability of financial support from **UNICEF**, EPI management teams were established at the regional and provincial levels and the EPI services has been extended to districts and subdistricts and success of seven of rounds of mass immunization campaigns/NIDs were the result of decentralized activities.*

*Another example is safe water supply project for which fund were available from various sources through **WHO**. This project was implemented in Kandahar, Ghazni, Jalalabad and Badakhshan. Community participation in co-operation of concern municipality are the keys factors for continuation and sustainability of this project.*

- *Establishment of co-ordination committees at central regional and provincial levels under the leadership of MOPH could successfully control the cholera emergency.*

- *Developing Health Information System **(HIS)** and its formats will enable us to collect the information and data from health facilities and make plan for management supervision monitoring of health activities. But till now we could not get sucess properly. We request from all organization to follow this format to have a unified system.*

- *In proposed organogram of MOPH for 1377 (1998) all the components of PHC are under one umbrella, and the vice directors of Public Healths in Provinces has the responsibility of PHC activities in provincial level.*

- *The detail information regarding acheivements of each project will be presented by regional representatives.*

Thanks

The Islamic Emirate of Afghanistan

Ministry of Public Health
Health Sector Planning Workshop
Kabul 15th Feb- First Mach 1998
Sponsored by MOPH,WHO & UNICEF

The translation of opening speech
by
His Excellency Alhaj Mulla Mohammad Abuss Akhund
Minister of Public Health

Very respected members of the Shura and my cabinet colleagues form the various Ministries of the Islamic Emirate of Afghanistan .
Representative of the Government departments.
Representative of the United Nation Agencies and NGOs and ICRC
Regional and provincial Health directors
Dear participants and friends and colleagues

Peace,Allah's blessing and prosperity be upon you.

In the Name of Allah the Merciful, The Compassionate.

All praises are due to Allah the Creator of Universes, Blesses and peace be up on Mohammad, his family and all his Companions.

It is said in the Holly Quran:

I have sent down from Quran what is blessing and heal for believers

The Prophet, peace be up on him, said:

For every ailment there is a medicament, if the medicament is given according to the ailment, with the will of Allah it will be cured.

I am pleased to welcome you all to this workshop in which we have decided to prepare the health plan for the coming year. As you know this is the first time in nearly 20 years, the MoPH has called for such an important meeting 22 public health directors along with the members of their health team to set together and discuss their progress and together with the aid agencies supporting the health sector to make the plan for the coming year.

The objectives of the workshop are as follows:

- Establishing the links between the capitals and the provinces
- Reviewing the 1997 work plan and collecting information about its implementation
- Recognizing the present health problems and taking decisions about their solution

- Recognizing the PHC strategies and its implementation in Afghan Health system
- Providing health services equally to the people of all villages, Sub-districts, districts and provinces
- Appointing health personnel from capital to provinces (Decentralization) and ifpossible, considering the priority of rational distribution of resources, facilities will be provided for them.
- Establishing and strengthening health surveillance and its implementation at the national level
- Last but not least, providing health for all by 21st Century

As you know, most the health facilities of Afghanistan specially in the provinces and districts, due to the two decade of war, have been destroyed and is not useable. According to the information available with the Ministry of Public Health there are 122 basic health centers and 28 sub-centers present in the whole country. But based on the information taken from foreign benevolent institutions from 315 basic health centers health services are offered to the people.

On the other hand, there were 64 provincial hospitals which were in the service of the Afghan and with the capacity of about 80 beds in the district level were active as Clinics and Hospitals. But unfortunately due to the unstable condition no accurate and complete data is available about them in the national level.

Beside all these destructions a number of our professional and experienced people have left the country and have been forced to migrate to abroad.

Because of these factors the health of the people of Afghanistan is deteriorating and at the present time, not enough health service is offered to the people to meet their needs, specially in the villages.

It has been estimated that about 156,750 children under one year of age and other 233,750 children under the age of five years die each year from diseases which can be prevented or treated.

On the other hand, from one million women who get pregnant 1,215 of them die from diseases caused by pregnancy or delivery.

The Ministry of Public Health endeavors to get local or foreign resources for the solution of the above mentioned problems. A budget of 47.5 Milliard Afghanis has been approved for the Ministry of Public Health of the Islamic Emirate of Afghanistan for the coming year form which 16 Milliard is for salaries and 31.5 Milliard for other expenses.

It is worth mentioning that funds for emergency cases can be obtained from the reserve budget of the Islamic Emirate.

Due to the kind attention of H.E. Amirulmominin three vehicles have been given for this workshop and it has been promised that transportation facilities will be provided for all provinces.

mechanisms, and standardisation of incentives provided to MOPH staff by aid community.

Another rather important lesson learned during the planning process is the different planning cycles of different health sector stakeholders. Most NGOs are operating on emergency budgets from donors on 3 to 6 monthly basis, UN agencies on 1 to 2 years basis and MOPH on a yearly basis. These planning cycles seriously hinder an effective and productive planning exercise done collectively by all the stakeholders. It is suggested that donors need to revisit their funding policies for health sector so that all health sector stakeholders can make a realistic and a common programme.

Therefore the Ministry of Public Health of the Islamic Emirate of Afghanistan, in the light of Islamic laws and Mohammadian Shariat, peace be up on him, will strengthen the following Policies and strategies:

1. Rehabilitation of the health system which will respond to the needs of the majority of the people of Afghanistan. Of course, the rehabilitation will take place with the help of donor countries, United Nation Organizations specially WHO and UNICEF, and National and International nongovernmental organizations.

2. Provision of Health services for the people in the frame work of regional PHC by the implementation of decentralization strategy.

3. About 80 % of the people of Afghanistan live in rural areas, availability to PHC services equally to all Afghans is included in our policy.

4. As the above mentioned statistics show that the mother and child mortalities are quiet high. By the implementation of maternal and child health program the improvement of their health is a part of our policy.

5. Strengthening the prevention and control of major health problems such as Malaria, Tuberculosis, acute respiratory infections, Diarrhoeal diseases, Vaccine preventable diseases such as Measles, Tuberculosis,Tetanus, Pertussis, Polio, Diphtheria, Malnutrition and Pregnancy related diseases.

6. Coordination of the assistance of foreign benevolent organization under the leadership of the Ministry of Public Health so that good relation may be established with them and facilities may be provided for them.

7. Provision of safe drinking water for our citizens specially in rural areas.

8. Establishing management teams and technical capacity to plan, implement, supervise and evaluate health programs at regional, provincial and district levels.

9. Introduction and /or strengthening the health information management and diseases surveillance system at district, provincial and regional levels.

10. Building capacity by in-service short and long term training of personnel inside and outside the country.

11. Physical and functional rehabilitation of some key infrastructures which have vital values for the development of primary health care such as rural basic health centers environmental health branch in Kabul, Institute of Malaria, leishmania and Parasitology the national, regional and provincial cold chains, Intermediate Medical Education Institute and Ibne Sena Pharmaceutical institute branches in the central and provincial level.

The main objectives of the health sector development under this policy, in the light of Islamic Shriat, will be the provision of health care through PHC program equally to all the people of Afghanistan.

It is hoped that this policy will give the Ministry of Public Health the competence to recognize the problems of the various regions and find the ways to solve them.

The Ministry of Public Health in collaboration with the donor countries, the World Health Organization, UNICEF, other UN agencies and NGOs will endeavor to operationalize the above policy and strategy and forge in inter-agency working mechanism that will ensure the implementation of a unified health care system in Afghanistan.

On behalf of the Islamic Emirate of Afghanistan, I would like to invite all our partners in the health sector to assist the Ministry of Public Health at the national, regional, provincial and district lever for the implementation of the above policy, In order to serve better the millions of the war affected Afghans.

At the end I would like to urge sincerely all of you present here to give your valuable contribution in this planning workshop to translate the above policy and strategy of the Ministry of Public Health into a realistic and achievable work plans for 1998.

I take this opportunity to thank all the participants of this workshop on behalf of the Ministry of Public Health and Islamic Emirate of Afghanistan, and I request Almighty Allah for your success.

(Peace up on you)

OPENING REMARKS OF
DR. ASHOUR OMAR GEBREEL
REPRESENTATIVE, WORLD HEALTH ORGANIZATION
AFGHANISTAN COUNTRY OFFICE
ON THE OCCASION OF THE OPENING CEREMONY OF
THE HEALTH SECTOR PLANNING WORKSHOP, KABUL
22 FEBRUARY, 1998

- HIS EXCELLENCY AL-HAJJ MULLAH MUHAMMAD ABBAS AKHUND, MINISTER OF PUBLIC HEALTH
- GOVERNMENT MINISTERS, HEADS OF DEPARTMENTS AND MEMBERS OF SHURA
- REPRESENTATIVES OF THE UNITED NATIONS AGENCIES, ICRC AND NGOs
- DEAR COLLEAGUES, LADIES AND GENTLEMEN:

It gives me great pleasure and honor to participate in this historic workshop in which representatives from 22 provinces together with their colleagues from the MoPH at central level have gathered to discuss and to share information and experiences in addressing the health problems in their respective provinces and regions with the representatives of the aid community.

I believe that this workshop will provide a unique opportunity to the stakeholders of health sector in Afghanistan, including MOPH, UN agencies, ICRC and the NGOs to critically review and analyze the health situation of the provinces and the regions represented here, with the aim to collectively formulate an effective strategy and a framework within which priorities for 1998 can be developed to respond to the real health problems of Afghan women, men and children. While doing it, may I urge all of us not to forget the health needs of those 80 percent of rural Afghan population who we have failed to reach effectively with our services and support.

We all know that long years of protracted conflict and instability of all kinds coupled with chronic under-investment, neglect and destruction of health and educational infra-structure have taken a serious toll on human health and growth, impairing and retarding health, social and economic development of this country.

The last decade in Afghanistan, in particular, has seen rapid and wide-scale increase in the incidence and prevalence of communicable diseases such as malaria, diarrhea, measles, pneumonia, tuberculosis, neonatal tetanus, pregnancy and labor-associated diseases which are claiming a heavy toll of maternal and child lives. It is estimated that tuberculosis alone claims 12,000 lives each year. Latest statistics indicate that 75 percent of all T.B patients under treatment are women from prime reproductive age group. Today's medical knowledge, indeed,

makes it possible to apply low cost interventions to prevent, treat and cure the majority of infectious and childhood diseases. Unfortunately this advance medical knowledge still needs to be translated into effective and viable strategies to curb the menace of disease in most parts of this country.

As a result, what we find today as health indicators in Afghanistan, are unfortunately one of the worst in the world. Infant and maternal mortality rate are one of the highest in the world and life expectancy is one of the lowest. Primary Health Care service coverage is at its lowest, especially in the rural areas. Estimates are that only about 35% to 40% of the total population has access to basic health services. However, on the positive side of the things I am happy to note that W.H.O with its sister organization UNICEF, Ministry of Public Health and NGOs, has been able to successfully undertake mass immunization campaign, including polio vaccination for the fourth successive year in 1997, covering 85 percent of the total children under five.

Notwithstanding the numerous problems faced by the health sector, the Ministry of Public Health in collaboration with the World Health Organization, the United Nations Children's Fund, ICRC and the NGOs is jointly endeavoring to reduce the disease burden of the people. Towards this end, the World Health Organization will continue to support the Ministry of Public Health, in its pursuance of the following policies and strategies, while taking into account the economic, socio-cultural and spiritual values of the people. This includes:

- Implementation of equity oriented health policies and strategies which are responsive to the health and social needs of the people and which guarantee equal access to the same quality of health care by female and male population.
- Incorporation of gender perspective into health policies, strategies and practices.
- Building a strong partnership for health between all stakeholders including the community organizations in support of developing a sustainable health care that can be maintained by the Afghans.
- Strengthening the regional approach to Primary Health Care development, under the decentralized health management system by establishing management structures at regional, provincial and district levels.
- Preventing and controlling diseases and protecting health of all segments of Afghan population.
- Developing gender and age sensitive health information systems and ensuring active surveillance.
- Building and maintaining human resources for health for both women and men which requires training for female and male health personnel.

In this context it is indeed encouraging to see the emergence of Regional Primary Health Care Framework, through which the Ministry of Public health is making an effort to revitalize de-centralized health delivery system, at the same time ensuring active role and ownership of it by the communities in reshaping and developing the health services delivery in Afghanistan. Indeed, as part of the Public Health Strategy, community leaders and health workers, both female and male, should take lead role in starting a popular education programme for the masses

about the deadly effects on human health of the evils like smoking and substance abuse. W.H.O will be ready for any partnership for an anti-smoking and anti-drugs campaign to promote healthy life styles.

The World Health Organization will also continue to support the expansion and implementation of an integrated community based development programme through the Basic Development Needs approach to strengthen communities initiatives in addressing the determinants of health, including poverty, unemployment, lack of access to credit facilities, and lack of access to information and knowledge to improve the quality of their life. WHO's experience from other countries demonstrates that this approach provides a platform for joint actions between the wider health sector, as defined by WHO's constitution, and the authorities and local communities, to work together as partners for peace and development in meeting the basic human needs through an indigenous, integrated and sustainable human development, which enhances investment and employment opportunities and facilitates the process of economic and social recovery, a pre-requisite for improving health status of the people.

On this occasion I will like to express my gratitude to the member states of WHO and to the donors for their relentless assistance, interest and generous donations which enabled us to make a reality of our objectives. Special thanks are also due to our sister organizations of the UN system for their valuable support to the health sector of Afghanistan.

The World Health Organization will continue to provide its technical, material and financial assistance, in partnership with MOPH, other UN agencies, ICRC and NGOs, for recovery and rehabilitation process of the health system in Afghanistan. It is going to be a long and challenging process which needs strong political commitment and leadership, decentralized management of health care system, resource mobilization, popular participation in the health care organization by both women and men, and above all, this process needs sustainable peace and stable environment.

In the end, on behalf of the World Health Organization, I would like to thank His Excellency Al-Hajj Mullah Abbas Akhund and his team in organizing this workshop and express my appreciation to the organizers and the technical committee who have worked day and night to prepare the workshop materials and to the support teams for taking care of the logistics and administrative work of the workshop. I would also like to express my appreciation and thank our traditional partner and sister agency in the United Nations system in the health sector: The United Nations Children's Fund-UNICEF for their technical, material and financial assistance in co-sponsoring this workshop with WHO and MOPH.

Before finishing my remarks, let me request you all to join me in praying that may God Al-Mighty help us in our efforts to make health services the means to build harmony and bring lasting peace to this country.

Thank you,

OPENING REMARKS BY MR. JIM MOHAN
REPRESENTATIVE, UNICEF AFGHANISTAN

At the inauguration of Health Sector Planning Workshop
Held in Continental Hotel - Kabul- Afghanistan

FEBRUARY 22-28, 1998

H.E. Minister of Health, Distinguished colleagues, Ladies and Gentlemen.

I am very pleased to be here with you this morning at the inauguration of this workshop on Afghanistan Health Sector Planning. First, let me express my thanks to the Ministry of Public Health for initiating the workshop, and welcome all Provincial health Directors, UN, ICRC, ECHO and NGOs partners both national and international, who are participating in this important workshop.

I noted that one of the objectives of this workshop is to promote coordination and cooperation amongst agencies, to develop the MOPH plan for 1998 and ensure better management of health services in Afghanistan. In addition, analysis of achievements and constraints from previous year will be made and appropriate adjustments made in the current year.

I understand that all the organizations represented here are closely engaged in the provisions of health services to reduce morbidity and mortality in Afghanistan. Effective strategies and planning require collaboration of several sectors, therefore UNICEF works closed with other agencies and many sectoral ministries which contribute to better heath services especially for children and women.

As part of preparation for this workshop, we know those Directors of various sections of MOPH and the Provincial Health Officers, attended the first phase of the workshop last week. I am confident that the outcome of last week's MOPH internal deliberations will provide useful input and form the basis for further actions during the second phase of the joint work planning process this week.

I would like to reiterate that UNICEF would continue to assist MOPH in implementation of the following priority projects in accordance with our ongoing programme of cooperation covering the period 1996-1999.

- Primary Health Care (PHC).
- Expanded Programme on Immunization (EPI).
- Maternal and Child Health/Safe Motherhood Initiatives(MCH/SMI).
- Control of Diarrheal Diseases and Acute Respiratory Infections (CDD/ARI).
- Control of Micro-nutrient Deficiency.

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UNICEF staff members will actively participate in this workshop and will further specify UNICEF's contribution to provision of much needed health services in Afghanistan. We all know that resources are finite against the backdrop of competing and overwhelming need. It is our hope that during the next six days your deliberations here will focus on well-known priorities of the country, including provision of basic support Hospitals and Primary Health Care Facilities, Emergency Health and Nutrition Requirements, Training and Human Resources and continued strengthening of the Expanded Immunization Programme.

UNICEF recognizes that throughout the world the key to the survival and to the continued health and well-being of children, and all family members, are women - as mothers, as sisters, as wives, and as daughters. In Afghan society today - where there is yet much to be done to provide institutional support to the health care of families-the role of women is all the more important. In order to make significant impact on the very high morbidity and mortality statistics of Afghanistan-which are among the worst in the world-we health agencies must find way to reach more families, in more rural areas, and we need more professional women to do so.

UNICEF requests all participants to give particular consideration to how women and girls can be supported and encouraged to participate fully-both as health workers and as beneficiaries-in all of our health programmes.

With continued commitment by major partners, I have no doubt that a lot can be done to ensure increased equal access to health services in order to reduce morbidity and mortality in Afghanistan.

It is our hope that our existing team spirits and partnership will continue in order to further strengthen our support to Afghanistan's children and women.

I wish you a very successful workshop.

Thank you.

1. INTRODUCTION:

The health sector of Afghanistan is undergoing a critical period, characterised by a changing environment in which demands for health services are increasing in the face of dwindling resources. Political, security, logistical, organisational and managerial constraints often make implementation of activities under the newly adopted decentralised management of health care quite a big challenge for the health care providers, managers and the policy makers.

Clearly, the poor health status of the Afghans, particularly children and women is the cumulative consequence of two decades of war followed by collapse of the social and economic sectors, high illiteracy rate, unemployment, massive migration and internal displacement, poverty and lack of functional central government, to mention just a few contributing factors. Destruction of a large number of health facilities and loss of equally large number of qualified professionals has left devastating impact on the quality and availability of health care services at all levels of the health care system. Any comprehensive and effective response, therefore, must recognise and address the range of problems in which the health sector is caught. Attempts are underway to seriously start the recovery process of the health sector, making it more equitable and responsive to the needs of the majority of the people, particularly the rural population, thus reducing the scale of the negative effects of ill health.

Health data - the basis for any health planning has always been sketchy, despite the existence of recording and reporting system in most of the regions. Some regions such as Herat, Jalalabad and, to certain extent, Kabul have more organised and somewhat reliable data collection system using the existing tools, than the other regions. The systematic use of epidemiological data has not been so far a widely exploited management tool for planning and intervention. Poor managerial knowledge and skills, lack of staff motivation, security and shortage of resources are often cited constraints hampering and hindering the effective implementation of health programmes.

In an attempt to improve the health service delivery system under the prevailing circumstances, the Ministry of Public Health in collaboration with WHO, UNICEF and NGOs has established Regional Health Management Teams (RHMTs) in six of the seven regions over the last three years. The function and performance of these teams vary from region to region, depending on the type and the size of support they receive from local authorities and external agencies. To support the implementation of Regional Primary Health Care Framework, the Ministry of Public Health is actively seeking assistance from WHO to strengthen the establishment of a database at provincial, regional and national level.

The issue of sustainability of health programmes has been of great concern to both the Ministry of Public Health and its partners assisting in the health recovery and rehabilitation process. At present, different stakeholders are using different strategies of cost sharing and cost recovery system. During the planning workshop the local health authorities supported the need to conduct more analytical studies of health care financing to inform policy development and standardisation of methods of cost sharing as a matter of high priority.

The need for all stakeholders to agree collectively on health priorities and to design comprehensive and integrated regional health plans, responsive to the health needs of the people was seen as the first step towards a new approach aimed at common programming with the collective strategic objective to improve the health status of the people through a coordinated and concerted effort by all stakeholders. This inevitably calls for a closer partnership between the local health authorities and the aid

community on the one hand and on the other hand a trusting relationship amongst the various stakeholders of the aid community itself.

As the first step in the process of preparing the regional health plans, the World Health Organization conducted a series of regional level pre-planning workshops, attended by the stakeholders of the health sector including Ministry of Public Health authorities from peripheral and central level, NGOs, UNICEF and the WHO. Nine provinces could not develop such plans of action because of the ongoing war and due to extreme cold conditions and are expected to prepare their plans once the conditions return to normalcy.

The regional pre-planning workshops were held in five regions (Jalalabad, Kandahar, Herat, Kabul, and Ghazni) and two provinces, i.e. Bamyan and Badakhshan. During the pre-planning workshops participants in each region were able to:

a) Undertake a comprehensive situation analysis using data collection forms and other tools developed for the workshop to analyse the health situation of their respective regions and develop both provincial and regional health profiles
b) Undertake an in-depth review of the status of achievements, constraints as well as the key lessons learned during the implementation process of the 1997 work-plans, specifically against the defined objectives and priorities of 1997 workplan
c) Identify a common set of priorities for 1998.

The outcome of the regional pre-planning workshops was further discussed at an inter-regional workshop on health sector planning held in Kabul between 15 February to 2 March 1998. The workshop was jointly organised and conducted by Ministry of Public Health, the World Health Organization, and the United Nations Children's Fund.

A total of one hundred and eleven (111) participants from various agencies and institutions attended the workshop. In addition to the Regional and Provincial health directors and their teams, representatives from 41 NGOs, 4 United Nations agencies and 2 field-based donors participated in the workshop.

The World Health Organization had developed simple tools to guide the participants through the whole process. These tools facilitated participants to undertake situation analysis, including systems and stakeholder analysis to make a rapid assessment of the capacities and experiences of their respective institutions, donors, government authorities especially Ministry of Public Health, national and international non-governmental organisations, United Nations agencies, communities and health professionals. This further aided the participants in the development and the selection of feasible strategies for programme interventions, implementation, identification of common priority programmes and monitoring mechanisms as well as rational decisions regarding logistical and financial systems taking into account the collectively available resources.

The workshop tried to capture, distil, and disseminate relevant information to assist the regional management teams in needs-based, realistic and achievable programme planning. Using the conventional tools of epidemiology combined with Participation, Reflection and Action (PRA) and the Logical Framework Approach (LFA), the five regional working groups built regional health profiles for their respective regions, which include information on health infrastructure (human resources and health facilities) and disease pattern, as well as preparation of detailed workplans for 1998 for their respective regions.

This report provides one of the most detailed health profiles ever developed in Afghanistan which include estimates of populations broken down by age and gender; with province-wise analysis of health facilities and their type; information on supporting agencies and coverage and package of services they provide; data on available human resources by category and gender and their distribution, and, lastly the disease profile in each region. The workshop also examined ways in which more effective and efficient use of the scarce resources available with health sector could be made through appropriate interventions strategies to reduce the key health problems contributing to the bulk of the disease burden and causing death and disability in Afghanistan.

The findings present a clear challenge to those who are at the centre of the Afghan health care development i.e. the national and the regional health authorities, the international community comprising the United Nations Agencies, the Non-governmental Organisations and the Donors. It is, however, recognised that the most critical change required for the effective implementation of the regional work-plans under the present situation, is the institutionalisation of the decentralised management of the health care system, backed by equitable distribution and investment of adequate resources.

The workshop was also designed to equip the participants with a new approach and concept in health programme planning and management by enhancing their planning skills and abilities to achieve better management of provincial health services with increased community participation. Focus has been placed in programme implementation through resource and operations management and also through application of simple participatory monitoring and evaluation mechanisms that can easily be carried out by the regional, provincial and district health management teams. Efforts were made to develop case studies from the local context with the aim to facilitate the understanding of the regional health management teams regarding the participatory methodology and approaches of planning and implementation of management changes. Broad-based participation and ownership of the management changes will, ultimately, contribute to the recovery and rehabilitation of the health system in Afghanistan.

2. OBJECTIVES OF THE WORKSHOP:

The overall objective of holding this workshop was to provide major stakeholders of the health sector an opportunity to engage in a collective process of reflection on the significant achievements and constraints experienced during the implementation of 1997 work plan, to identify key health problems, decide priorities for 1998, undertake resource analysis and translate all this into regional work plans for 1998, ensuring equitable spread and distribution of assistance to both urban and rural communities.

The workshop was run into two phases. The first phase was more of an in-house pre-planning workshop of MOPH personnel, similar in objectives as were the pre-planning workshops run in the regions prior to the conduct of the planning workshop. This phase was held from 15 February till 21 February 1998. The second phase, which was run from 22 February to 2 March 1998, was attended by all the stakeholders of health sector in Afghanistan.

Specific objectives for each of the two phases of the workshop are given below.

2.1 The objectives of the first phase were:

- To discuss operational aspects of the reorganisation of the health care system under the prevailing situation.

- To review and analyse the health situation in 20 provinces and deliberate on the health priorities, bearing in mind the implications of the ongoing war on the implementation process.

- To brief and discuss with the regional health teams the new functions of the central level of MOPH structure and agree on the working modalities and responsibilities of the regional directorates and the type of support the regions can expect from the centre under the decentralised health management system.

2.2 The objectives of the second phase included:

- Information sharing by all participating agencies i.e. WHO, UNICEF, WFP, UNHCR, NGOs, ICRC, IFRC and donors to orient MOPH on their organisational mandate, modus operandi and their strategy(s) for health care in Afghanistan and vice versa.

- Information sharing by each of the participating stakeholder on their respective area of expertise/assistance, the geographic coverage of their programme, the cost, major achievement in 1997 against individual work plans, and constraint analysis with suggested proposals to overcome major barriers to implementation of their work-plans.

- Sharing by the individual participating stakeholders of the respective priorities identified and the indicative or absolute budget for 1998.

- Discussion and agreement on a common set of priorities for 1998 and development of consolidated regional work plans for 1998, by building on the output of the regional pre-planning workshops which took place in each of the five regions in early February of this year.

3. METHODOLOGY

The methodology developed by WHO for the workshop is people-centred and guided by the basic principles of adult learning. It used tools and methods from Participation, Reflection and Action (PRA) and ZOPP (objectives oriented intervention planning). A resource person from WHO was assigned to introduce the tasks and the process for each session of the workshop at plenary, inviting questions for clarification. Participants ware divided into five working teams by their regions. Agencies working in more than one region had the free choice to move around. Facilitators from WHO and UNICEF guided the whole planning process.

The participants were expected to jointly assess the progress on the implementation of 1997 work-plan, analyse its achievements, constraints and draw up the key lessons learned. In the process of developing the regional work-plans, the participants were asked to review the priorities for 1998 which were identified by the regional health teams during the recent regional pre-planning workshops organised in early February 1998 by WHO. This review also took into account the available resources and the capacity of each region in implementing and sustaining the programmes. Working groups also examined and analysed the basic and underlying causes of the health and medical problems identified in their respective regions. They employed the "But Why" and "If-Then" technique in problem analysis to be able to select the most appropriate strategic objectives, prioritised them and developed feasible strategies to solve the health problems. The participants were then required to translate these strategies into detailed action plans with budgets, implementation schedule and monitoring indicators for each of the activities in the action plan. Notes on procedure, formats and examples were given for each of the exercise.

REPORT OF HEALTH PLANNING WORKSHOP

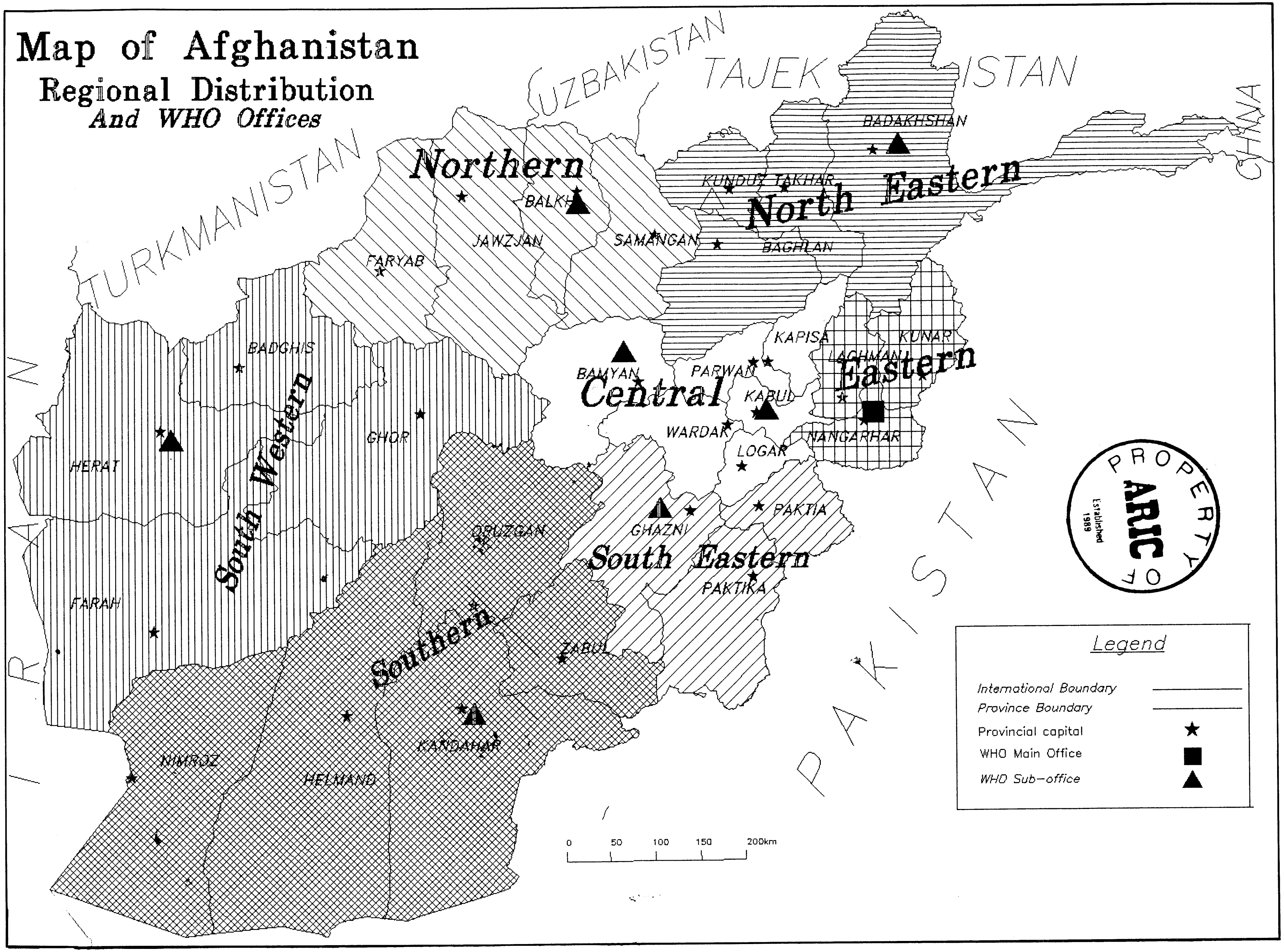
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Map of Afghanistan
Regional Distribution
And WHO Offices



ABBREVIATIONS

1.	ARI	Acute Respiratory Infection
2.	BCG	Bacillus of Calmette Guerin
3.	BDN	Basic Development Needs
4.	CBA	Child Bearing Age
5.	CDD	Control of Diarrhoeal diseases
6.	DD	Diarrhoeal diseases
7.	DPT	Diptheria, Pretussis, Tetanus
8.	EPI	Expanded Programme of Immunization
9.	HIMS	Health Information Management System
10.	LBW	Low Birth weight
11.	LFA	Logical Framework Approach
12.	LEISH	Leishmaniansis
13.	MCH	Maternal and Child Health
14.	MSLS	Measles
15.	MALNUT	Mal-nutrition
16.	MoPH	Ministry of Public Health
17.	NGO	Non-Governmental Organization
18.	OOIP	Objective Oriented Intervention Planning
19.	OPV	Oral Polio Vaccine
20.	PHC	Primary Health Care
21.	PRA	Participation, Reflection and Action
22.	PHMT	Provincial Health Management Team
23.	RHMT	Regional Health Management Team
24.	SMART	Simple, Measurable, Accurate, and Time-bound indicator
25.	TB	Tuberculosis
26.	T.B.A	Traditional Birth Attendants
27.	UN	United Nations
28.	UNICEF	United Nations Children' s Fund
29.	VHV	Village Health Volunteers
30.	WHO	World Health Organization
31.	ZOPP	Ziehl Orientierte Project Planning

TABLE OF CONTENTS

Title	Page No.
Preface	1 – 2
Executive Summary	3 – 5
Introduction	6 – 8
Objectives	8 – 9
Methodology	9 – 10
Outputs	10
Findings	11 - 28
Monitoring and Evaluation	29
ANNEXES	
▪ Summary Regional Work plans	I – V
▪ Summary Regional Profiles	VI – X
▪ Main Issues and Recommendations	XI